

Women's Health Programs in New York State



New York State
Department of Health

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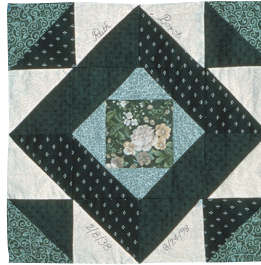
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Introduction

New York State's commitment to women's health is demonstrated by the variety and depth of public health programs and services that are currently offered to the women of the state. New York delivers a wide array of women's health services throughout the state, recognizing that improving and sustaining access to high-quality, continuous primary and preventive health care and treatment services are critical to eliminating disparities in health outcomes and to achieving public health priorities. Major components of the provision of quality health care services include prevention, early intervention, and continuity of care.

In 2002, the New York State De-Research Inc. was awarded a grant Women's Health Services in State focus of the grant is to improve the de-wide through enhanced coordination partners providing health care services velopment of more comprehensive and women's health across the life span.



partment of Health through Health titled the Integrated Comprehensive Maternal Child Health Programs. The livery of women's health services state-and collaboration among the many to women. This will result in the de-integrated approaches to coordinating

The development of this program profile is the first step towards the accomplishment of these goals. This document contains valuable information regarding programs and services offered by the New York State Department of Health targeted towards women as well as program contacts for more information. We hope that this will serve as a valuable resource for locating and providing health care services to the women you serve throughout the state.

For more information on Department of Health programs, see the New York State Department of Health's Web site at www.health.state.ny.us, or for the name of the program provider nearest you, call the Growing Up Healthy hotline at 1-800-522-5006.

Alzheimer's Disease Programs

Background: Dementia is a progressive loss of intellectual and physical function. Alzheimer's disease, a neuro-psychiatric disorder, is a leading form of dementia. Physiological symptoms include destruction of cells in the central nervous system, which results in impairment of memory, reasoning, judgment, psychomotor skills and activities of daily living. Although it is not thought to occur as a natural consequence of aging, Alzheimer's disease usually strikes people 65 years of age and older. In addition to the degenerative symptoms the Alzheimer's patient experiences, the family caregivers become socially isolated and overburdened physically, emotionally and financially. Not only do more women than men develop Alzheimer's disease, but women provide a disproportionate amount of the community care for people with the disease. Currently, 70% of the persons with Alzheimer's reside in the community and family caregivers provide 75% of their care.

The number of individuals with Alzheimer's disease and related dementias in New York State is quickly reaching crisis proportions. While over 400,000 New York residents are currently estimated to have this condition, the elderly population in NYS is expected to increase significantly during the next several years, especially the proportion of the population over 80 years of age. Consequently, the incidence and prevalence of Alzheimer's disease and related disorders is expected to increase dramatically in New York State. The increasing numbers of individuals with Alzheimer's disease will overwhelm the current system unless programs to serve this population can be expanded.

Program Description: New York State funds nine Alzheimer's Disease Assistance Centers (ADACs) which serve as "centers of excellence" for the diagnosis and management of Alzheimer's disease and other dementia patients. These programs are located in or affiliated with major teaching institutions. The ADACs function as a comprehensive community resource regarding Alzheimer's Disease and other dementias and ensure, by coordinating a network of providers and services, that appropriate diagnostic testing, refer-

als, services, family support, professional training and community education are available in their catchment areas. The ADACs provide directly, arrange for, coordinate, and/or contract for services; this maximizes existing resources and reduces the duplication of effort among various agencies. Each Center serves a defined geographic area based upon its capabilities and size, travel time to the Center, and availability of related services in nearby geographic areas.

The State also funds ten Alzheimer's Disease Community Service Programs (CSPs) that provide essential family/caregiver support, respite care, information and referral services to patients with Alzheimer's disease, and their families. The purpose of the Alzheimer's Disease CSPs is to reduce the enormous toll of Alzheimer's Disease and other dementias on patients and their families by promoting effective patient management, education, and appropriate support for caregivers, community agencies, and self-help groups.

The program seeks to establish and maintain local initiatives, particularly in areas that are traditionally underserved, to assure that patients are cared for in their community for as long as appropriate after onset of the disease. The Alzheimer's Disease Community Service Programs collaborate with regionally funded Alzheimer's Disease Assistance Centers.

The target population is individuals with Alzheimer's Disease and their caregivers. Many of those caregivers are wives and daughters of patients with Alzheimer's. It is estimated that almost 18,000 patients and family caregivers have been served by the various programs offered by the ADACs and the CSPs.

Contact: New York State Department of Health
Alzheimer's Disease Programs
Riverview Center
150 Broadway, Third Floor West
Albany, NY 12204

Telephone : (518) 474 -1222

Web : www.health.state.ny.us/nysdoh/consumer/alzheimer/alzeihm.htm

Arthritis Program

Background: Arthritis and other rheumatic diseases affect approximately 4.7 million adult New Yorkers (2001 BRFSS) with 1.5 million of those aged 65 or older. Arthritis is more common among women, those with less than a high school education (42%) and those with a body mass index (BMI) of 30 or higher (45%).

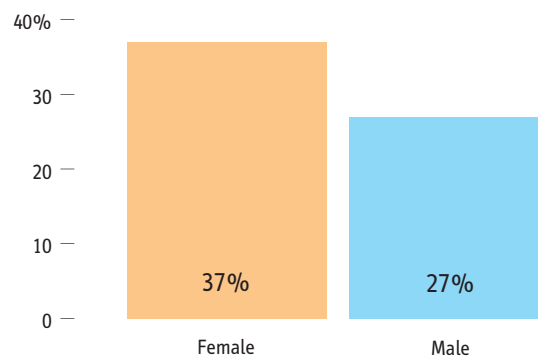
Program Description: The Arthritis Program's main objectives are to define and reduce the burden of arthritis and related diseases in New York State, prevent and reduce the disability associated with them, and improve the quality of life for those with arthritis and related diseases.

The Arthritis Program is currently:

- Incorporating arthritis messages into chronic disease prevention, health promotion and education initiatives, and other programs of the DOH.
- Promoting effective interventions to manage the disease, reducing the limitations of activities experienced by individuals with arthritis, and extending the reach of self-management programs into underserved areas of New York State.
- Utilizing the CDC physical activity promotional materials targeting those with arthritis and developing educational materials targeting low income/low education populations.

Working in collaboration with the Arthritis Foundation and the New York State Office for the Aging

Adult New Yorkers with Arthritis



(NYSOFA), the Arthritis Program is offering the Arthritis Self Help Course in targeted areas of the state. The Arthritis Self Help Course is a proven intervention, which has demonstrated a reduction in physician visits and pain associated with arthritis. Many of the participants in the course are women in whom certain forms of arthritis such as osteoarthritis, rheumatoid arthritis, and lupus are more prevalent.

Contact: New York State Department of Health
Arthritis Program
Riverview Center
150 Broadway, Third Floor West
Albany, NY 12204

Telephone: (518) 408-5141

Web : www.health.state.ny.us/nysdoh/chronic/arthritis.htm

Healthy Women Partnership Program

Background: Breast cancer is a serious health problem in New York State, with more than 14,800 new cases and 2,800 deaths reported each year. Breast cancers represent over 28% of all new malignancies among women. A disproportionate number of deaths from breast cancer occur among low-income and minority women over the age of 40 who, despite understanding the benefits of early detection, may not have access to screening. Although cervical cancer represents a smaller threat to the women of New York than breast cancer, there are still over 300 deaths from this preventable disease each year, many among older women. Rural women and women who have recently emigrated from other countries, in particular, find access to cervical cancer screening services to be a problem. There is also a misconception among older women that it is not necessary to continue pelvic examinations and Pap Testing beyond childbearing years.

Program Description: The New York State Healthy Women Partnership Program operates through 54 local partnerships comprising a total of 2,334 community partner agencies statewide. The program has provided nearly 350,000 mammograms and almost 100,000 Pap smears to low-income, uninsured women in New York State. More than 2,000 cases of breast cancer, 37 cases of cervical cancer and nearly 1,200 precancerous cervical lesions have been detected in women screened through the program. Cancers are detected at even earlier, more curable stages among women who return for annual screening in this program. Currently, the partnerships are expected to screen approximately 60,000 women each year.

The priority population for screening through the Healthy Women Partnership Program is women ages

40 and older who are at or below 250% of the federal poverty guidelines and who have no health insurance or whose health insurance does not cover screening or diagnostic services. Women between the ages of 18 and 39 are eligible for a clinical breast exam, Pap test and any associated diagnostic testing. Of special concern are ethnic and racial minority groups and women who are medically underserved because they live in isolated rural communities. The Department estimates that 550,000 women meet the eligibility criteria for program services in New York.

In addition to screening services, the Healthy Women Partnership Program provides diagnostic and case management services, and assists women diagnosed with breast and cervical cancer in obtaining prompt comprehensive treatment. In October 2002 Governor Pataki signed legislation that expands Medicaid eligibility to women diagnosed with breast and cervical cancer or precancerous cervical conditions through the Healthy Women Partnership program. In the first year of this new coverage, over 300 women received coverage for the duration of their treatment. The program also provides public education about cancer risk factors and the importance of early detection, and maintains a rigorous quality assurance review on services provided to clients.

Contact : New York State Department of Health
Healthy Women Partnership Program
Riverview Center
150 Broadway, Third Floor West
Albany, NY 12204

Telephone : (518) 474 -1222

Web : www.health.state.ny.us/nysdoh/cancer/center/cancer_services.htm

Colorectal Cancer Screening and Prostate Education Initiative

Background: Colorectal cancer is the second leading cause of cancer related death in the United States. In New York, colorectal cancer is diagnosed on average in over 10,300 people annually and about 4,000 men and women will die from this disease each year. Fortunately, early detection and removal of colon polyps can often prevent colon cancer. Prostate cancer is the second leading cause of cancer related death in men. In New York, prostate cancer is newly diagnosed in more than 14,000 men each year and more than 1,800 men die from this disease annually. Yet, few men understand the threat or accurately assess their risk for this disease.

Program Description: In 1997, the State Health Department established the Colorectal Cancer Screening and Prostate Education Initiative (CPI), a unique program using local initiatives throughout the State to increase the availability of colorectal and prostate cancer education and routine colorectal screening to underserved and uninsured populations age 50 and older. From August 20, 1997 through August 31, 2003 the program provided more than 32,000 screenings and, from those, 46 individuals were diagnosed with colorectal cancer and 179 were diagnosed with adenomatous polyps (the precursor to colorectal cancer).

The purpose of this program is to prevent colorectal cancer and increase the early detection of colorectal cancer, thereby reducing the mortality rate for colorectal cancer. An additional goal is to raise public awareness about colorectal cancer prevention and the issues

surrounding prostate health and the early detection of prostate cancer. These programs coordinate with local Healthy Women Partnerships to become the foundation of an integrated approach to providing cancer education, screening and early detection services for priority populations.

Currently, 30 community-based partnerships involving 43 counties provide the following services:

- Implementation of community-based education activities to inform men and women of the need for and availability of colorectal cancer screening with distribution of fecal occult blood test (FOBT) kits;
- Assurance of the availability of colorectal cancer screening, as well as diagnostic and case management services and affordable treatment options for the uninsured population;
- Linkage of colorectal cancer education and screening to existing services for underserved and uninsured population where feasible and appropriate; and
- Education about prostate health, prostate cancer and issues related to screening and treatment.

Contact : New York State Department of Health
Colorectal Cancer Screening and Prostate
Education Initiative
Riverview Center
150 Broadway, Third Floor West
Albany, NY 12204

Telephone : (518) 474-1222

Web : www.health.state.ny.us/nysdoh/cancer/center/cancer_services.htm



Diabetes Control and Prevention Program

Background: Diabetes is one of the most burdensome and costly chronic diseases. The rate of diabetes in New York State is on the increase, with 6.7% of the population (956,000 residents) known to have diabetes, up from 4.2% in 1996. Women, who represent more than half of all persons with diabetes, are at particular risk for developing diabetes and its complications. This is due to the fact that women have an increased life span, and also because some risk factors for diabetes (weight gain during pregnancy, gestational diabetes) occur only in women. Among African-Americans, women are also more likely to be obese than men. Among women in New York State, those 65 years of age and older have the highest burden of diabetes with a prevalence rate of 17.6%. Complications that can result from sub-optimally managed diabetes represent a significant cause of morbidity and mortality and include heart disease, stroke, blindness, kidney failure, leg and foot amputations, pregnancy complications, and deaths related to flu and pneumonia.

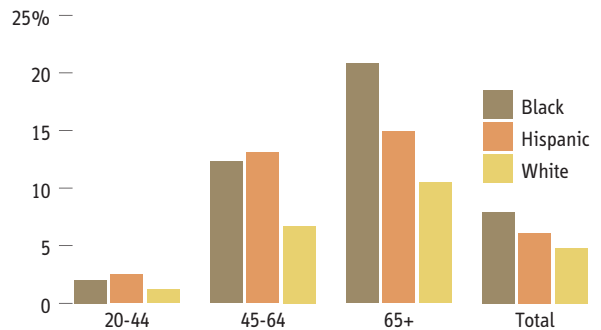
Diabetes in pregnancy is a serious condition that can affect the health of both the mother and baby. In New York State approximately 9,500 births occurred in women with pre-existing or gestational diabetes in 2000. The rate of birth to women with gestational diabetes is on the rise, increasing from 3.4 in 1996 to 3.7 in 2000. From the 2002 Behavior Risk Factor Surveillance System (BRFSS), it is estimated that 140,000 women (2.2% of all women) statewide had gestational diabetes, but do not have diabetes now. They represent a group of women who have a high risk of developing Type 2 diabetes in the future.

Minority women are at particular risk for diabetes. National figures estimate that the prevalence of diabetes is at least 2-4 times higher among black, Hispanic, and American Indian women than among white women. In New York State, minorities of both sexes also bear a greater burden of diabetes.

Program Description: The Diabetes Control and Prevention Program sponsors a number of initiatives to address high-risk populations:

- Community Coalitions for Diabetes Prevention (13 funded statewide) provide outreach, diabetes self-management education and community awareness events for at-risk populations, as well as

Estimated Diabetes Rates by Age and Race/Ethnicity for New York State, 1997-1999



professional education for the providers who care for them.

- Pilot projects for the Governor's Initiative for Children with Diabetes which team comprehensive diabetes centers, schools, local chapters of the Juvenile Diabetes Research Foundation and the American Diabetes Association, hospitals, and managed care organizations. Their purpose is to improve the availability and quality of diabetes care and information for school-aged children, their families, and school personnel.
- Diabetes surveillance activities assess the extent of the diabetes burden in New York State. A comprehensive diabetes surveillance report is produced on a regular basis. In addition, specialized surveys to investigate the prevalence of diabetes and its risk factors were conducted with funding from the Centers for Disease Control and Prevention and the Association of Schools of Public Health.
- Collaboration with a variety of nationally based efforts to improve diabetes care for underserved populations, including the Diabetes Collaborative and National Asian Women's Health Organization.
- Diabetes publications are produced, updated and shared with statewide partners on a regular basis including a recent CDC monograph entitled "Diabetes and Women's Health Across the Life Stages."

Contact : New York State Department of Health
Diabetes Control and Prevention Program
Riverview Center
150 Broadway, Third Floor West
Albany, NY 12204

Telephone : (518) 474-1222

Web : www.health.state.ny.us/consumer/diabetes/index.htm

Disability and Health Program

Background: One in five New Yorkers (3.4 million) report having a disability due to an impairment or a health condition. Data indicate that as the population of persons over age 65 increases, both the total number and the percentage of persons with disabilities will also increase. National data sources document that the direct medical and indirect annual costs associated with disability are more than \$300 billion, or 4 percent of the gross domestic product. This total cost includes \$160 billion in medical care expenditures (1994 dollars) and lost productivity costs approaching \$155 billion.

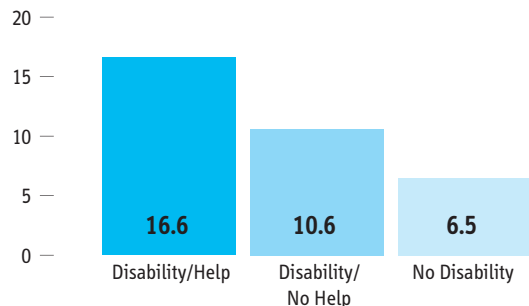
The health promotion and disease prevention needs of people with disabilities are still very real despite being born with or acquiring an impairing condition. People with disabilities have increased health concerns and susceptibility to secondary conditions. Having a long-term condition increases the need for health promotion.

Health promotion programs that focus on improving functioning across a spectrum of diagnoses and a range of age groups are effective in reducing secondary conditions and outpatient physician visits among people with disabilities. Not only do women comprise a larger part of population than men, they are also more likely to report having a disability.

Program Description: The Disability and Health Program (DHP) encourages Department of Health programs, as well as other organizations serving community residents, to conduct interventions that include persons with disabilities to prevent or ameliorate secondary complications. Professional education efforts include programs to teach providers how to adapt generic services to meet the needs of persons with disabilities. Health promotion opportunities need to be both physically accessible and programmatically accessible such as providing information in alternate formats. The Disability and Health Program also targets persons with disabilities with information on how they can practice behaviors that reduce the risks of common secondary conditions.

Women in the United States with physical disabilities are less likely to receive preventive health care for breast and cervical cancer than women without physi-

Percentage of Underinsured Women Aged 18-64, by Disability Status, 1998-2000



Had Insurance but Could Not Afford Needed Doctor Visit Past Year

cal disabilities. According to the NYS BRFSS, they are also more likely to engage in high-risk behaviors, including cigarette smoking, being overweight and not getting enough exercise. They are also more likely to report barriers in accessing preventive health care.

Disability and Health Program initiatives targeting women with disabilities have included:

- A videoconference held as part of the NYSDOH Women's Health Grand Round series targeting ob/gyn and family practice physicians on barriers to reproductive health care and health screening for women with disabilities
- Collaboration with the NYSDOH Office of Managed Care to support a community based education program for physicians in meeting the needs of women with disabilities in the community
- Placement of 20 accessible examination tables in Healthy Women Partnership provider sites coupled with education of providers in clinical assessment techniques and disability sensitivity and awareness training.
- Development of a mammography self study module for women with disabilities for radiology technicians.
- Development and distribution of numerous pamphlets, brochures and videos on preventive health behaviors for women with disabilities.

Contact : New York State Department of Health
Disability and Health Program
Riverview Center
150 Broadway, Third Floor West
Albany, NY 12204

Telephone : (518) 474-2018

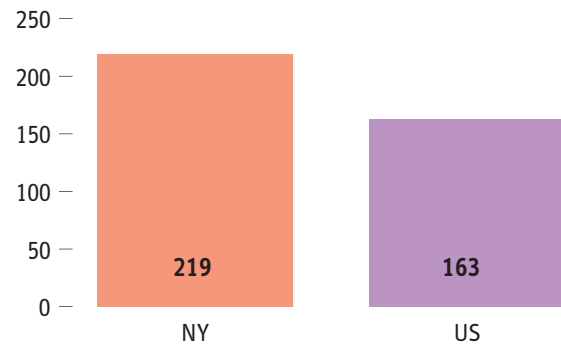
Web : www.health.state.ny.us/prevent/main.htm

Healthy Heart Program

Background: Often the symptoms of heart attack and heart disease are less apparent in women than in men; once diagnosed with heart disease, the outcome for women is generally poorer than that of men. Each year, since 1984, more women have died as the result of cardiovascular disease than men. Surveys show that most women are far more afraid of breast cancer than of cardiovascular disease, yet breast cancer accounts for less than 4 percent of all deaths of women in New York, while cardiovascular disease accounts for 47 percent. The crude death rate for women from stroke exceeds that for men by 34 percent. Heart disease caused 31 percent of all deaths in New York in 1999; 22,549 men and 27,021 women in New York died from heart disease. Heart attack is the leading cause of death among women in New York State. Among women, cardiovascular disease claims more lives than the next 16 causes of death combined.

Program Description: In the late 1970s, the Department of Health developed the New York State Healthy Heart Program (HHP) to reduce premature death and disability from cardiovascular disease (CVD). Local community-based programs are funded in counties around the state to educate and inform individuals about the major risk factors associated with CVD and to make local environments more supportive of a heart healthy lifestyle. In addition, the HHP conducts professional education and training for health care providers. Communication campaigns to promote physical activity and the consumption of low-fat milk have also been initiated. Core messages about what builds strong and healthy hearts have reached into every New York county: be smoke free, eat fruits and vegetables and low-fat dairy products, be active for at least 30 minutes every day and get your blood pressure and cholesterol under control. The Healthy Heart Program reaches more than 100 communities around the State and over 500,000 people, making it easier for New Yorkers to choose healthy behaviors.

Coronary Heart Disease, Female Death Rates* NY and US, 1999



* Rates are age-adjusted to the US 2000 population.

The Healthy Heart Program also funds a Women and Heart Disease Education Initiative, to improve the quality of care for women with heart disease through increased physician training and education. The funding allows the American College of Obstetricians and Gynecologists (ACOG) and the American College of Physicians/American Society of Internal Medicine (ACP/ASIM) to provide training of health professionals to improve the diagnosis and treatment of heart disease, particularly in women. As part of this initiative, seminars are conducted and teaching aids developed to help physicians better recognize the risk of heart disease in women in order to improve prevention and promote early diagnosis and treatment.

Contact : New York State Department of Health
Healthy Heart Program
Riverview Center
150 Broadway, Third Floor West
Albany, NY 12204

Telephone : (518) 474-6683

Web; www.health.state.ny.us/nysdoh/heart/healthy/healthy.htm

NYS Comprehensive Tobacco Use Prevention & Control Program

Background: In 2002, just over one in four (22.3%) adults 18 and over in New York State were cigarette smokers. Currently, 19.2% of all women are smokers. Cigarette use varies by age. Smoking rates are generally higher among younger adults. The highest percentage of women smokers are aged 35-44 (26.9%), followed by women 45-54 (24.5%), women aged 18-24 (21.7%), and 25-34 year olds (17.4%).

The consequences of smoking among women in New York State are enormous. Between 1996 and 2000, deaths in females aged 35 to 64 due to lung cancer occurred at the rate of 38.4 per 100,000 whereas deaths due to breast cancer occurred at the rate of 30.1 per 100,000. Of all lung cancer deaths in females, 77% can be attributed to smoking. In 1999, 83% of deaths among women due to bronchitis and emphysema were attributable to smoking. Moreover, 42% of women who died of stroke and 34% who died of heart attack, were due to smoking.

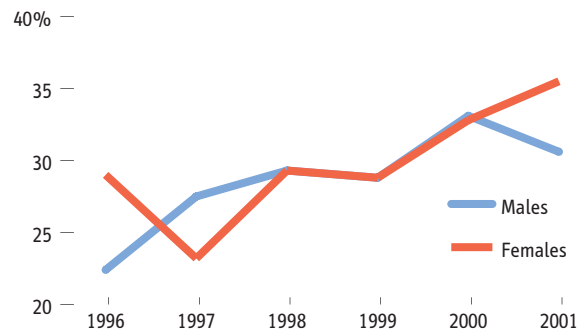
It is estimated that 80% of adult smokers began using cigarettes before the age of 18. During 2002, a survey of New York State youth indicated that 21.3% of high school students and 6.7% of middle school students have smoked cigarettes on one or more of the past 30 days, and that 56.9% of high school students and 28.6% of middle school students have ever tried cigarettes. At both the middle school and high school level, boys and girls are equally likely to have smoked cigarettes in the past 30 days.

Program Description: The Tobacco Control Program is designed to improve the health, quality of life and economic well-being of all New Yorkers by preventing and reducing tobacco use. The program focuses on

- preventing the start of tobacco use by youth and young adults;
- promoting smoking cessation among adults and youth;
- eliminating exposure to environmental tobacco smoke; and
- identifying and reducing disparities related to tobacco use and its effects on different populations.

The program is multi-faceted and brings together communities, advocates, retailers, health care provid-

Prevalence of Current Smokers Ages 18-24 years, by Gender, New York State BRFSS 1997-2001



ers, schools and others in the fight to reduce or eliminate tobacco use in New York State by:

- mobilizing citizens and changing community perceptions and attitudes about tobacco through community-based and youth empowerment initiatives;
- paid media directed at adults to promote cessation and counter-marketing activities directed at communities in order to normalize and de-glamorize tobacco use, and counter tobacco industry promotional activities;
- school-focused prevention initiative to support the implementation of effective tobacco-free school policies;
- cessation resources and programs at the state and local level to provide smokers with the services and support they need to successfully quit smoking; and,
- enforcement of minors' access to tobacco laws to reduce the availability and accessibility of tobacco products to youth.

The program is administered primarily through contracts with local health departments, community-based organizations, health care providers and others.

Contact : New York State Department of Health
Tobacco Control Program
Empire State Plaza
Corning Tower, Room 710
Albany, New York 12237-0676

Telephone : (518) 474-1515

Web : www.health.state.ny.us/smoking/main.htm

New York State Osteoporosis Prevention and Education Program (NYSOPEP)

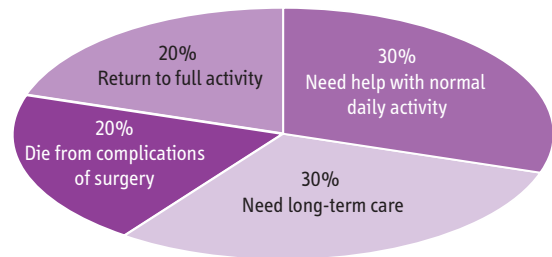
Background: Osteoporosis is a large – and growing – public health problem. New York has one of the nation's largest elderly populations and thus a large population at risk for osteoporosis. It is estimated that approximately 3 million New York women and men over the age of 50 have osteoporosis or low bone mass and over 70 percent of individuals with osteoporosis disease are undiagnosed. In 2000, New Yorkers suffered more than 77,000 bone fractures, at an estimated cost of \$821 million. More than 1 million women and over 250,000 men in New York State are expected to have a spine, hip or forearm fracture during their lifetime. Most fractures in older individuals can be attributed to osteoporosis. The annual cost of treating fractures related to osteoporosis, in New York State alone, is expected to increase to over \$1 billion by 2025.

In New York State, over 40,000 seniors aged 65 and over are hospitalized each year due to fall-related fractures. The mean length of hospital stay is 13 days. In addition, a catastrophic consequence of fracture is that 28% of this population requires discharge to a nursing home facility.

Osteoporosis begins in childhood with poor diet and exercise habits, and may go undetected until a fracture occurs in old age. While there is no cure for osteoporosis, evidence has shown that prevention, early diagnosis and treatment are key in reducing the prevalence and debilitating effects of the disease.

Program Description: The Osteoporosis Education Bill (Article 27A of the Public Health Law) was signed in 1997. The bill established the New York State Osteoporosis Prevention and Education Program within the Department of Health. The program promotes public awareness of the causes of osteoporosis, options for prevention, the value of early detection and possible treatments. The law also created an Osteoporosis Advisory Council to advise the Department on the

Consequences of Hip Fractures



prevention and treatment of osteoporosis, including the development of educational materials and the establishment of public education campaigns.

The program plan consists of four components:

- Establishment of a public education and outreach campaign to promote osteoporosis prevention and education that will allow individuals to make informed choices about their health.
- Adaptation of educational materials for consumers, particularly targeted at high risk groups, disseminated through contractors, local health departments, health care providers, and others.
- Training of health care providers in the area of osteoporosis diagnosis, prevention and treatment.
- Adaptation of professional education materials for health care providers.

Six regional osteoporosis resource centers provide comprehensive programs of public and professional education regarding the prevention, diagnosis and treatment of osteoporosis in their geographic areas.

Contact: New York State Health Department
Osteoporosis Prevention and
Education Program
Empire State Plaza
Corning Tower, Room 1805
Albany, NY 12237

Telephone: (518) 474-1911

Web site: www.health.state.ny.us/osteo/index.htm

Ovarian Cancer Information and Education Program

Background: Each year, more than 1,700 women are newly diagnosed with ovarian cancer in New York State, and more than 1,000 die of the disease. Because ovarian cancer is often not diagnosed until it has spread beyond the ovary, ovarian cancer is the fifth most common cause of cancer death among women in NYS. Although considered by some to be a “silent killer”, new data suggest that the majority of affected women have symptoms, even in early stage disease.

Program Description: In the absence of data justifying general population screening, the goal of the NYS Ovarian Cancer Information and Education Program is to educate women and their health care providers about risk factors, symptomatology and appropriate testing for high-risk and symptomatic women.

The NYS Ovarian Cancer Information Advisory Council was established in 1997 by Governor George Pataki and is made up of health care providers, survivors, and representatives of ovarian cancer organizations. The purpose of the Council is to advise the NYS Department of Health on all issues related to ovarian cancer.

With the help of the Council, the Program has produced materials on ovarian cancer in English and Spanish. These include a brochure for the general public: “Ovarian Cancer – What You Need to Know” and a poster for providers’ offices: “New York State Cares About Ovarian Cancer”. Two quilts made up of squares created in honor of survivors and in memory of women who did not survive travel around the state to increase awareness.

In 2003, 14 small grants were awarded under the Ovarian Cancer Education and Awareness Initiative. These projects, located around the state, have the ultimate goal of earlier detection, leading to more effective treatment and reduced mortality from this disease among NYS women.

Other activities include a NYS Ovarian Cancer email list which aims to increase communication and collaboration among gynecologic oncologists, survivors, representatives of ovarian cancer organizations, and others, “Teaching Days”, radio spots and public service announcements, and periodic meetings among ovarian cancer stakeholders and Advisory Group members.

Patients and families interested in genetic testing and meeting the criteria set forth in “Genetic Susceptibility to Breast and Ovarian Cancer: Assessment, Counseling and Testing Guidelines” developed by the American College of Medical Genetics with support from the NYSDOH, are referred to qualified genetic counselors around the state. The Guidelines are available on the NYS Department of Health Web site.

Contact: New York State Department of Health
Ovarian Cancer Information and
Education Program
Riverview Center
150 Broadway, Third Floor West
Albany, NY 12204

Telephone: (518) 474 –1222

Web: www.health.state.ny.us/cancer/ovc/index.htm



Abstinence Education and Promotion Initiative

Background: The past two decades have seen a significant change in adolescent pregnancy in New York State. The pregnancy rate in teens aged 15–19 increased from 78.1 per 1000 in 1980 to a high of 95.3 per 1000 in 1993. Although rates have gradually declined, they are still unacceptably high at 75.8 per 1000 in 2000. Some of the serious adverse consequences of adolescent pregnancy include:

- Teen mothers are twice as likely to receive little or no prenatal care.
- Infants born to teen mothers are at higher risk for low birth weight and infant morbidity and mortality.
- Children born to teens may suffer a variety of developmental impairments and are at risk for child abuse.
- Behaviors that place adolescents at risk of pregnancy are also responsible for the alarmingly high incidence of HIV and other sexually transmitted diseases.
- Unhealthy adolescent sexual behaviors often continue into later adult life, contributing to unintended pregnancy and transmission of HIV and sexually transmitted diseases.

Program Description: The Abstinence Education and Promotion Initiative (AEPI) provides abstinence education and mentoring, counseling and adult supervision to promote abstinence from sexual activity, focusing upon those groups at highest risk for bearing children out-of-wedlock. Developed from the Personal Responsibility and Work Opportunity Reconciliation Act (Welfare Reform) in 1996, the Act created a new formula grant program to “enable the State to provide abstinence education, and ...men-

toring, counseling and adult supervision to promote abstinence from sexual activity with a focus upon those groups which are most likely to bear children out-of-wedlock.”

Program activities include the development of community-based initiatives that address the root causes of premature sexuality and change community and adolescent mores related to its acceptability. Efforts include:

- community information and education efforts to sensitize the public about the local need to promote abstinence from sexual activity among adolescents;
- outreach to high-risk youth;
- education that promotes abstinence and delays the onset of sexual activity;
- efforts to enhance parent/child communication about sexuality;
- youth development activities, including educational, recreational and vocational opportunities and efforts designed to improve self-esteem and develop life options and decision-making skills;
- after school programs;
- peer and adult mentoring and counseling;
- efforts targeted to young males; and
- implementation of a statewide media campaign designed to support community-based efforts.

Contact: New York State Department of Health
Abstinence Education and
Promotion Initiative
Empire State Plaza
Corning Tower, Room 208
Albany, NY 12237

Telephone : (518) 486-4966

Community-Based Adolescent Pregnancy Prevention Program

Background: Adolescent pregnancy is one of the most critical public health problems facing New York State today. Since 1980 there has been a significant change in adolescent pregnancy rates in New York State. The pregnancy rate in teens aged 15 – 19 increased from 77 per 1000 in 1980 to a high of 95 per 1000 in 1993. Although rates have gradually declined, they are still unacceptably high at 75.8 per 1000 in 2000.

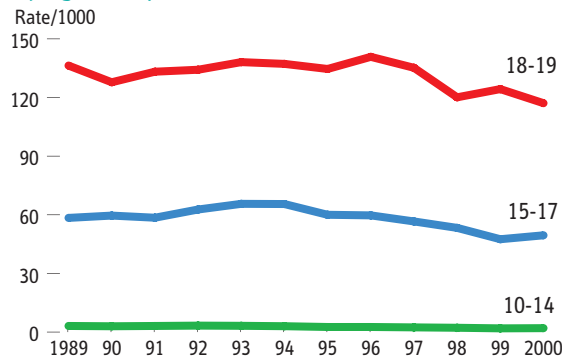
Program Description: The Community Based Adolescent Pregnancy Prevention (CBAPP) Program seeks to provide adolescent pregnancy prevention activities in areas with high pregnancy rates among teens to delay the onset of sexual activity among youth, and for those adolescents who are sexually active, ensure access to disease control and contraception.

This program was established in 1995 with ten ZIP codes targeted for services. The program has expanded the number of codes being served each year to 54 in 2000. There are three primary program strategies: promote abstinence and delay the onset of sexual activity among all adolescents; expand educational, recreational, vocational and economic opportunities for teens to provide alternatives to sexual activity and develop skills that can lead to higher earning power and reduce the need for public assistance; and provide access to comprehensive family planning and reproductive health care services to prevent pregnancies, STDs and HIV.

Program activities include:

- development and maintenance of comprehensive preventive programming requiring long-range planning efforts and substantial community involvement;

Adolescent Pregnancy Rate per Thousand by Age Group, NYS, 1989-2000



- engaging youth and key community resources to help reduce adolescent pregnancy and promote positive youth development;
- working with peers, parents, schools, community health and human services organizations, local governments, businesses and the media;
- providing community information and education to sensitize the public about the local need to address the prevention of unintended pregnancy;
- involving junior high/middle schools in abstinence-oriented preventive programming; and
- promoting use of peer educators to reach adolescents at risk of unintended pregnancy through the provision of medically accurate information; by identifying social pressures and responses to these pressures; and by teaching assertiveness skills.

Contact: New York State Department of Health
Community-Based Adolescent Pregnancy
Prevention Program
Empire State Plaza
Corning Tower, Room 208
Albany, NY 12237

Telephone: (518) 486-4966

Comprehensive Family Planning and Reproductive Health Care Services Program

Background: The proportion of unintended pregnancies in the U.S. is almost 50%, which is substantially higher than in other industrialized nations. There is a well-established correlation between unintended, particularly unwanted, pregnancies (as distinct from mistimed pregnancies), and reduced educational attainment, poverty and welfare dependency, poor health and mental health outcomes and neglect, abuse and violence. These negative consequences of unintended pregnancies affect not only pregnant women, but also their children, partners and families.

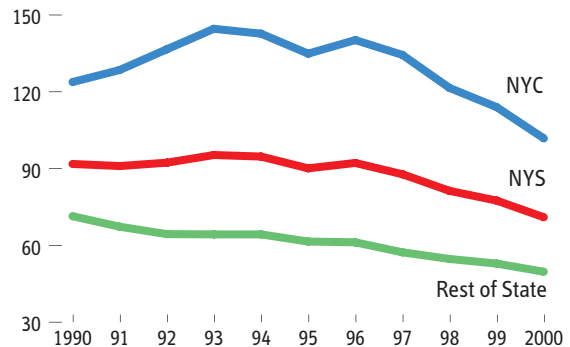
Women's lifelong wellness is a continuum, with her reproductive health playing an integral part in the whole. In addition, family planning services may represent a woman's sole point of contact with the health care system. This, in turn, raises the importance of these services in maintaining a woman's overall level of wellness throughout the life span, by increasing the responsibility of reproductive health care providers for screening and referral to other services needed to maintain wellness.

Program Description: In 59 agencies in 218 sites, family planning programs provide accessible reproductive health services essential to meeting key public health objectives. Programs provide low-income, uninsured women with contraceptive education, counseling and methods to reduce unintended pregnancies and therefore abortions (one measure of unintended pregnancies. See graphic above) and to improve birth spacing and outcomes. Programs provide counseling and testing for HIV and testing and treatment for STDs, and they facilitate early detection and treatment of breast and cervical cancer through routine screening. They provide health education in community settings to promote reproductive health, to prevent adolescent and adult unintended pregnancy and to promote access to reproductive and preventive health services. Currently over 330,000 women receive services through the family planning program, and 100,000 of these are teenagers.

The program serves predominantly low-income clients, with 68% of all clients having incomes below 100% of poverty. In addition, the program serves disproportionately minority clients, with less than half of clients served reported as Caucasian.

The Family Planning Extension Program (FPEP) provides up to 26 months of additional access to family planning services for women who were pregnant while on Medicaid, and subsequently lost Medicaid coverage.

Teenage (15-19) Pregnancy Rates in NYS, 1990-2000



Providers are reimbursed off-line for services rendered under this program, using claims submitted through the individual client-record based data collection system.

Federal Law (known in New York as the free access policy) allows individuals enrolled in Medicaid managed care plans to obtain family planning and reproductive health services from any Medicaid participating provider (in or out of a managed care plan's network), without referral or prior approval of the plan. A comprehensive public education campaign related to free access has been implemented by the Bureau of Women's Health and the Office of Managed Care and includes the dissemination of materials for providers, enrollers, and clients related to the free access policy, statewide training and funding of regional providers to provide outreach and education related to free access.

In FY 2000-01 legislation was enacted to expand Medicaid eligibility for family planning services to individuals with incomes up to 200% of poverty. As a result of this legislation, the Bureau of Women's Health in conjunction with the Office of Medicaid Management developed a Medicaid waiver to further expand coverage for family planning services. The waiver, approved for implementation on October 1, 2002, permits eligibility for all New York State men and women who are not otherwise Medicaid eligible, and who have incomes at or below 200% of the federal poverty level.

Contact : New York State Department of Health
Comprehensive Family Planning and
Reproductive Health Care Services Program
Empire State Plaza
Corning Tower, Room 1805
Albany, New York 12237

Telephone : (518) 474-3368

Sexually Transmitted Disease Control Program

Background: Sexually transmitted diseases (STD) are the most common communicable infections reported in New York State, accounting for 80 percent of all communicable disease morbidity. In 2001, over 20,000 persons in upstate New York with syphilis, gonorrhea, and Chlamydia were reported to the Department of Health (see Table).

Women bear the burden of STD. The complications of untreated infection with Chlamydia are severe. An estimated 6,000 women develop pelvic inflammatory disease each year with approximately 50 percent requiring hospitalization; of these, 1,500 will develop complications including infertility, ectopic pregnancy, and chronic pelvic pain. Annually, approximately 100 women in New York State die of cervical cancer caused by infection with genital human papilloma virus. Infection with an STD increases the risk of acquiring HIV 3 to 5 fold.

Who Is At Risk: All sexually active individuals are at risk of acquiring an STD.

Prevention and Control Measures: The mission of the Bureau of Sexually Transmitted Disease Control (BSTDC) is to prevent and control sexually transmitted infections among residents of New York State. BSTDC achieves this mission through the successful integration of program activities, including surveillance, case management, partner notification for STDs including HIV, STD screening, provider and patient education, quality assurance, and research and evaluation.

Program Priorities: The top program objectives are to provide prompt identification of STD infection in New York State through disease surveillance, case management and investigation, and screening. Priority is placed upon the identification of pregnant women with syphilis infection and prevention of congenital syphilis, followed by prevention of complications of STD infection such as infertility, ectopic pregnancy, cancer, and neonatal infection.

Target Population: Disease intervention activities are based on local rates of infection and infrastructure needs. In essence, Bureau resources are targeted to the areas with the highest burden of infection. In addition to these 'core' geographic areas, BSTDC focuses screening activities on adolescents and young adults as rates of infection are highest among this population group. Finally, the Bureau evaluates the existing capacity to intervene and prioritizes targeting resources where local capacity is inadequate.

Number of People Served: The combined resources of the county and state health departments provides the capacity to provide diagnostic and treatment services to approximately 22,000 upstate residents and to conduct epidemiologic investigations on 5,000 reported cases annually – the latter representing approximately 18 percent of reported cases.

Initiatives Targeting Women: The Infertility Prevention Project is a federally-funded initiative that aims to reduce the prevalence of Chlamydia and its sequelae by promoting the development of efficient systems for screening, diagnosis, and management of Chlamydia among women and their infected partners. The New York State Infertility Prevention Project is a collaborative effort of the Bureaus of STD Control and Women's Health. Chlamydia screening is provided to women in a variety of public health clinics throughout New York State. The New York State Infertility Prevention Project belongs to the Region II Infertility Prevention Project with partners from New York City, New Jersey, Puerto Rico, and the U.S. Virgin Islands.

Contact: New York State Department of Health
Sexually Transmitted Disease Control Program
Empire State Plaza
Corning Tower, Room 1168
Albany, N.Y. 12237

Telephone: (518) 474-3598

Web : www.health.state.ny.us/nysdoh/communicable_diseases/en/index.htm

Syphilis, Gonorrhea and Chlamydia Infection among Women in New York State by Age - 2001

			Age Group							
		Total Cases	<10	10-19	20-29	30-39	40-49	50-59	60+	Unk.
Syphilis	Primary Stage	4	0	1	2	1	0	0		
	Secondary	19	0	5	6	6	1	1		
	Early Latent	157	0	23	49	52	23	8	2	
	Late Latent	1,252	0	18	200	465	315	117	125	12
	Total	1,432	0	47	257	524	339	126	127	12
Gonorrhea	Total	11,873	26	4,773	5,235	1,277	359	52	18	133
Chlamydia	Total	38,303	36	14,805	18,384	3,623	807	166	80	402

Centers of Excellence in Pediatric HIV Care

Background: The pediatric HIV epidemic has changed dramatically since the mid-1990s. The number of seropositive women giving birth in New York State declined from 1,885 in 1990 to 838 in 2000, nearly a 56 percent reduction. The introduction of antiretroviral prophylaxis against perinatal transmission has reduced the rate of that transmission from an estimated 25 percent in the early 1990's to 3.7 percent in 2000. As a result, fewer infected babies are being born, and, due to improved medical management of HIV disease, the children who are infected are living longer, healthier lives and aging to adolescence. Centers of Excellence in Pediatric HIV Care are designed to meet the complex medical management needs and the unique psychosocial and educational support needs of these children as they grow and develop while living with HIV.

Program Description: Centers of Excellence in Pediatric HIV Care are key players in community/regional systems to prevent perinatal HIV transmission and to care for pregnant women with HIV and their HIV-exposed children. To fulfill this role, a Center promotes access to its programs, provides consultation to community providers and birth facilities, and accepts referrals for the direct provision of comprehensive care and services for HIV-exposed newborns and children with HIV.

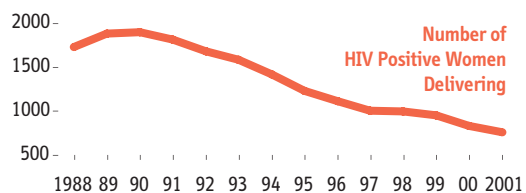
The target population is HIV-positive children, including HIV-exposed infant whose infection status has not been determined. If access to specialized HIV health care for adolescents with HIV infection is limited or not available, the target population also includes HIV-positive adolescents and young adults.

Children with HIV infection may have significant mental health, neurological or developmental problems due to the impact of HIV on their developing nervous systems, as well as the environmental issues such as poverty, parental drug use and malnutrition. Mental health, neurological and developmental assessments by qualified staff are integrated into the services provided on site at the Center. These services include:

Core Services

- Client recruitment;

NYS Survey of Childbearing Women HIV Prevalence by Year of Delivery: 1988-2001



Source: New York State Perinatal HIV Surveillance Program

- HIV care, provided by a full-time pediatric HIV specialist;
- 24-hour coverage, 7-days a week, with access to a pediatric HIV specialist;
- Treatment education and adherence support;
- Clinical trials and appropriate study/treatment protocols;
- Comprehensive pediatric primary care;
- Mental health assessments;
- Nutritional assessments;
- Family-centered case management and community follow-up services;
- Social work;
- Concrete supportive services;
- Educational and prevention services which are age- and developmentally-appropriate;
- Client-centered support services; and
- Transitioning services to adolescent or adult care.

In addition, Centers of Excellence in Pediatric HIV Care either provide or have established linkages for the following expanded services:

- Mental health services provided by a trained child/family therapist with experience in treating children and families with HIV;
- Pediatric dental care;
- Nutritional services; and
- Pediatric subspecialty care.

Contact : New York State Department of Health
AIDS Institute
Bureau of HIV Ambulatory Care Services
Empire State Plaza
Corning Tower, Room 442
Albany, NY 12237

Telephone : (518) 486-6048

Web : www.health.state.ny.us/hiv aids/aboutai/women

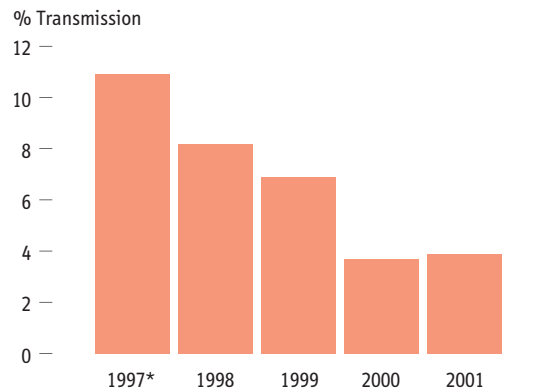
Community Action for Prenatal Care (CAPC)

Background: New York leads the nation in reported pediatric AIDS cases with over 25% of the total cumulative cases reported to the CDC. Women who do not seek prenatal care are a link in the chain of events leading to an HIV infected child. There have been declines in the number of HIV-positive women giving birth and in the percent of HIV-positive child-bearing women with no prenatal care. These factors, combined with an increase in the rate of prenatal HIV testing among all women presenting for delivery, have led to a decline in the perinatal transmission rate from 10.9% in 1997 to 3.9% in 2001. Continued prevention efforts are needed to reduce this even further by targeting the most hard-to-reach women.

Program Description: The Community Action for Prenatal Care (CAPC) project involves the development of community coalitions dedicated to the reduction of adverse birth outcomes, including perinatal HIV transmission, through the recruitment of high-risk women into prenatal care. The target population is likely to be found among the following groups: adolescents, immigrants, substance users, women experiencing homelessness and/or mental illness, women with developmental disabilities and women in a domestic violence situation. The initiative is targeting ZIP codes of the Bronx, Brooklyn, Manhattan and Buffalo where the percent of women delivering with no prenatal care and the rate and/or number of HIV-positive women giving birth are both high. CAPC combines the expertise of HIV, maternal/child health and substance abuse programs by including them in service delivery and other coalition activities.

A lead agency in each of the target areas is responsible for coordinating the activities of the community coalition, including implementation of a comprehensive model for reaching high-risk pregnant women not in prenatal care. The basic elements of the comprehensive model are: local planning, recruitment/referrals (including a social marketing campaign, hotline services, enhanced outreach by specially trained outreach workers and

Perinatal HIV Transmission Rate, NYS, 1997-2001**



Percent of deliveries by HIV positive mothers that resulted in HIV transmission to the baby

*Feb-Dec 1997

**p<0.05 using chi square for trends

referrals from health facilities and agencies serving high risk women); intake and transitional case management; user-friendly prenatal systems; case management/advocacy. Another unique feature of CAPC is the focus on the individual woman and her psychological barriers to care. Enhanced outreach workers are taught that it may take multiple encounters to build a trusting relationship with an individual woman who is reluctant to enter the health care system.

CAPC Results – 2002: Intake was completed on over 1,015 women during 2002; 54% were pregnant and 10% suspected pregnancy. Routine outreach and social marketing were the most productive pathways into care for CAPC women in 2002.

Contact : New York State Department of Health
AIDS Institute
Bureau of HIV Ambulatory Care Services
Empire State Plaza
Corning Tower, Room 459
Albany, NY 12237

Telephone : (518) 473-8427

Web : www.health.state.ny.us/hiv aids/aboutai/perinatal/htm.bak

Family-Centered HIV Health Care Services

Background: In New York State, many families affected by HIV are also affected by poverty, substance abuse, domestic violence, mental illness and family disruptions. These issues, along with family responsibilities and access issues, present significant barriers to health services. Health care services often fail to recognize that HIV often affects several generations and extended family members and the role of HIV-infected men as caregivers and the importance of the father's involvement in the care and treatment of his family have been largely overlooked. A family-centered approach to HIV health care recognizes and respects the family as the constant force in the client's life and seeks to reduce access barriers, improve the health status of HIV-affected families and support families in their care giving roles.

Program Description: Family-Centered HIV health care programs are based on family values, priorities and needs and provide a supportive, respectful care environment. They promote a holistic approach to family health linking medical psychosocial and other concrete services to meet the needs of families. Programs encourage new community partnerships and greater involvement of families in planning their health care. Collaboration between families and professionals in making care decisions is an essential component of the family-centered approach.

The target population for this program is families affected by HIV. Women and men living with HIV and their dependent children/adolescents are eligible for program services. These services include:

Core Services

- Client recruitment;
- HIV counseling and testing services;
- Prevention services to assist clients with HIV in modifying their behavior to reduce risks to others and further risks to themselves;
- Comprehensive medical services, including;
- HIV care provided by an HIV Specialist;

- Primary medical care, including gynecological and reproductive health care for women,
- Nutritional assessments and screening for sexually transmitted diseases;
- Colposcopy and related services and referrals for specialty gynecologic care;
- Mental health and substance use assessments;
- Client-centered treatment education and adherence monitoring;
- Prenatal care coordinated with HIV specialty care;
- Social work;
- Family-centered case management;
- Partner notification assistance services;
- Screening and referral for domestic violence;
- Care coordination, assessment of service needs, and care plan development;
- Supportive and educational services to remove interpersonal and social barriers to care; and
- Concrete supportive services, e.g., transportation, childcare, language interpretation, and peer supportive activities.

Expanded Services

- Mental health services and crisis intervention;
- Substance use services;
- Nutrition services;
- Dental services;
- Specialty gynecologic care;
- Child life services;
- Pediatric HIV care provided by a pediatric HIV specialist; and
- Pediatric primary care for HIV-infected and affected children.

Contact : New York State Department of Health
AIDS Institute
Bureau of HIV Ambulatory Care Services
Empire State Plaza
Corning Tower, Room 442
Albany, NY 12237

Telephone : (518) 486-6048

Web : www.health.state.ny.us/nysdoh/hiv aids/aboutai.htm

Women at high risk for HIV and Women living with HIV/AIDS

Background: In New York, HIV has increasingly become a women's disease. New York State residents account for over 25 percent of all reported United States AIDS cases among women. In New York, the HIV epidemic among women has increased dramatically over the last 15 years. Adolescent and adult women accounted for 26.6 percent of AIDS cases diagnosed in New York State in 1999, compared to 19.8 percent in 1990 and 10.3 percent in 1985.

HIV is increasingly affecting persons of color, particularly women. Women of color represent a disproportionate number of new AIDS cases. Among cumulative female AIDS cases in New York State through June 2000, 53.7 percent are Black; 30.9 percent Hispanic; 14.9 percent White; 0.3 percent Asian/Pacific Islander, and 0.03 percent Native American. The predominant route of HIV exposure for women is injection drug use; however, an increasing proportion of new AIDS cases are attributed to heterosexual contact with 31.08 percent reporting such contact as their primary HIV risk through June 2000. Although HIV seroprevalence among childbearing women has decreased statewide since 1990, it remains high in metropolitan areas and among African American Women. HIV Seroprevalence among the 251,465 women whose newborns were tested in 2000 was 0.3 percent with 830 testing positive.

With these findings the New York State Department of Health/AIDS Institute implemented initiatives tailored to focus on the following: women, particularly women of color, at high risk for HIV infection and women living with HIV, their partners and families.

HIV Prevention Services for Women: A solicitation was released and applications were reviewed in 2002. Twenty-eight agencies were selected for funding. One component of this RFA addressed HIV prevention services for women and was a resolicitation of existing CDC, State and Ryan White funding that supported HIV prevention services for women and early identification and intervention services for pregnant women and their newborns.

Programs funded to provide HIV prevention services for women through this initiative will:

- promote HIV prevention interventions to sus-

tain behavior change over time and reduce the risk of HIV transmission or acquisition;

- promote interventions to increase the motivation of women to know their HIV status;
- increase access to voluntary testing at community-based organizations and health care settings utilizing the latest testing technologies available and approved for use by the New York State Department of Health;
- reduce perinatal HIV transmission by providing early access to primary prevention and HIV counseling and testing recommended for pregnant women and women of childbearing age;
- increase awareness among women at risk for HIV and women living with HIV of how Sexually Transmitted Diseases (STDs) increase the risk of HIV transmission and facilitate access to STD prevention, screening and treatment; and
- recruit and engage women into comprehensive systems of HIV prevention, support and health care services.

The key components/service areas of this initiative include: HIV counseling and testing in clinical, community-based, and outreach settings; targeted and enhanced outreach to recruit and engage at-risk and HIV infected women who are not engaged in ongoing prevention, care and/or supportive services; multi-session individual and group prevention interventions provided to women at-risk and women living with HIV to minimize future transmission or acquisition of HIV; strong referrals, linkages and follow-up to needed services for both at-risk and women identified as HIV positive.

Women's Supportive Services: Implemented in 1992 and resolicited in 2001, the Women's Supportive Services Initiative is targeted to women living with HIV, their partners and families and expands the availability of HIV-related services for women and their families and strengthens the referral linkages between hospital-based HIV CTRPN programs and community-based health and social services providers. This initiative represents a unique public/private partnership in which the Institute provides programmatic oversight and the United Way of NYC provides technical assistance and fiscal administration.

Ten CBOs located in Manhattan, Bronx, Queens, and Brooklyn are funded through this initiative (through

State, Ryan White Title II, and United Way of New York City funding) to provide family-centered case management, individual level and group level prevention interventions (ILIs and GLIs), community follow-up, and supportive services to HIV-infected women and their families. In addition to case management, they provide a range of supportive services: child care, 24-hour crisis intervention, emergency financial assistance, transportation, housing assistance, individual and group counseling, support groups, peer support, and HIV prevention education. All funded programs provide individual and group HIV prevention interventions for women living with HIV/AIDS to decrease HIV transmission. Individual level interventions may be incorporated into existing HIV case management services, and group level prevention interventions may be incorporated into ongoing support and education groups.

Participating programs provide services to approximately 2,000 women living with HIV/AIDS and over 1,000 family members and partners each year. State, federal (HRSA) and private funds support this initiative. Seventy-four percent of the clients are female and 26 percent are males. Forty-eight percent are African American, 37 percent are Hispanic, 13 percent are white, and 2 percent represent other racial/ethnic groups. The age range of indexed clients served is as follows: 1 percent are adolescents (below the age of

20), 34 percent are between the age of 20-24, 61 percent are between the ages of 25-49, 4 percent are over the age of 50.

General information about HIV/AIDS in New York State can be found by visiting the web at: www.health.state.ny.us (click on the HIV/AIDS button at the top of page for AIDS Institute resources and information).

You can also call one of the following General HIV Information Hotlines, which provide basic information such as HIV transmission, prevention, testing procedures & referrals to local providers by county of residence.

AIDS Hotline: (800) 541-2437

Spanish (800) 233-7432

TDD (800) 369-2437

Contact : New York State Department of Health
AIDS Institute
Women's Services Unit
5 Penn Plaza, 1st Floor North
New York, NY 10001

Telephone: (212) 268-6273

Web: www.health.state.ny.us
(click on the HIV/AIDS button at the top of page for AIDS Institute information).



Youth-Oriented HIV Health Care Programs

Background: Persons under 25 years of age account for 10 percent of newly diagnosed HIV cases across New York State. Numerous national, state and local studies have shown that young people living in, or experiencing, certain specific situations are at increased risk for HIV infection. Such situations include young people who:

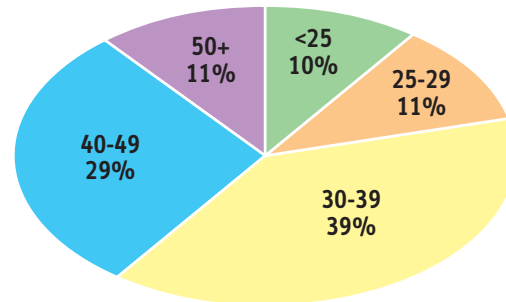
- are not in school;
- are incarcerated or recently released from incarceration;
- are prostitutes;
- use substances (e.g., alcohol, inhalants, injection drugs);
- are homeless or have run away from home;
- have parents/caregivers who are HIV-positive;
- are sexually or physically abused; and
- are in social networks whose members engage in high-risk behaviors.

Youth-Oriented HIV Health Care Programs care for youth at risk or who are HIV-infected through innovative case funding strategies and the development of a continuum of services through partnerships with community organizations that serve youth. This community approach builds on partnerships of health providers, youth-serving organizations, the social networks of youth, and other community resources. It seeks to reach those youth whose life circumstances place them at highest risk and facilitates access to the concrete services that at-risk youth need to prevent and treat HIV infection.

Program Description: The target population includes adolescents and young adults, ages 13 to 24 years, who have HIV or are at high risk for HIV infection. The target population includes, but is not limited to: lesbian, gay, bisexual, questioning or transgender youth; young men who have sex with men; youth who use substances, and other young people in high-risk situations. Two types of programs are funded by this initiative:

Specialized Care Centers provide comprehensive health care and supportive services to address the needs of adolescents or young adults who have HIV or are at high risk for HIV. In addition to providing comprehensive services on site, the Centers develop linkage agreements to create a continuum of services needed by young people. Centers are funded to pro-

Distribution of HIV Cases by Age
Tested 6/1/200 - 12/31/2000



vide client recruitment, HIV prevention education, individualized risk assessment and health promotion, HIV counseling and testing, comprehensive medical services, case management, supportive counseling, concrete supportive services and peer support. In addition, programs provide mental health and substance use assessments with referral to or provision of treatment, if indicated. All services are designed to help youth increase self-esteem and build daily living and coping skills.

Youth Access Programs provide low-threshold clinical services in accessible community-based settings to meet the immediate health care and social service needs of at-risk youth. In many cases, these needs must be met before or concurrent with addressing issues related to HIV testing and treatment. Methods for implementing low threshold clinical services include the use of mobile multidisciplinary teams, part-time clinics in community-based settings, and medically equipped vans. Programs are funded to provide client recruitment, HIV prevention and risk reduction services, HIV counseling and testing, immediate primary health care for acute illnesses, access to pharmaceuticals, pregnancy testing and family planning services, screening and treatment for sexually transmitted diseases, psychosocial assessments and transitional case management.

Contact: New York State Department of Health
AIDS Institute
Bureau of HIV Ambulatory Care Services
Empire State Plaza
Corning Tower, Room 442
Albany, NY 12237
Phone: (518) 486-6048

Food and Nutrition Program (FAN)

Background: New York State's Commodity Supplemental Food Program (CSFP), known as the Food and Nutrition (FAN) Program offers free, nutritious foods and nutrition information to low-income pregnant women, postpartum women (through twelve months), children to age six and low-income elderly (aged 60 and over).

Supplemental foods are annually distributed to approximately 38,000 participants per month at five full-time and 61 part-time (mobile) food distribution sites located in the counties of Nassau, Suffolk, Brooklyn and Queens.

Contact: New York State Department of Health
Food and Nutrition Program
Riverview Center
150 Broadway, Sixth Floor West
Albany, New York 12204

Telephone: (518) 402-7098

Web : www.health.state.ny.us/nutrition/fan/about



Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

Background: WIC's purpose is to improve pregnancy outcomes, promote optimal growth and development for infants and children and influence lifetime nutrition and health behaviors. The WIC program provides supplemental food, nutrition education/counseling, and linkages with health and social services for low-income eligible women and children at no cost.

To enroll in the WIC program, an individual must be:

- Pregnant, breastfeeding, or postpartum women; or,
- An infant, or child under the age of five; and
- Identified by a WIC-certified professional authority (CPA) as having a nutrition/medical risk;
- A New York State resident; and
- Have income of 185% of federal poverty guidelines or less.

WIC eligibility is determined by WIC local agencies that follow USDA guidelines. There are 103 WIC local agency providers that operate over 534 WIC clinic sites located in every county and major city in New York State. WIC local agency providers are sponsored by organizations including:

- 56% hospitals, family planning or medical and health center sponsors;
- 24% county health departments sponsors; and,
- 20% community action or not-for-profit sponsors.

WIC checks are used to purchase prescribed foods such as iron-fortified cereal, cheese, beans, eggs, peanut butter, juice, milk, tuna fish, carrots, and iron-fortified infant formula. These foods are good sources of one or more of the key nutrients, such as iron, calcium, and vitamins A and C, often missing from the diets of women and young children.

Program Initiatives: The goal of the WIC program is to encourage healthy lifestyles through targeted nutrition education on a variety of topics:

- The Farmers Market Nutrition Program (FMNP) is designed to encourage low-income families at nutritional risk to increase their consumption of fresh fruits and vegetables through the issuance of “checks” that may be redeemed at participating Farmers Markets throughout the State. FMNP also complements the Department of Health’s “Eat Well, Play Hard” initiative that encourages the consumption of vegetables and fruits to improve general health and to help reduce the risk of chronic diseases. FMNP provides an incentive for WIC families to try fresh produce and encourages them to consume more vegetables and fruits. By introducing participants to farmers markets through the FMNP, it is believed that they will develop an interest in purchasing fresh produce and continue to frequent these markets.
- The WIC program provides local agencies with peer counselor programs, manuals, videos and other professional resources to promote breastfeeding in the WIC population. Annual breastfeeding rates before hospital discharge for both exclusive and partial breastfed infants for 2002 totaled 134,466 (58.46%). Breastfeeding promotion efforts included the expanded availability of breast pumps for purchase or rent at local agencies. WIC CPA staff are being offered Certified Lactation Counselor training. Promotional items are provided on an ongoing basis such as breastfeeding education videos, reference materials, educational tools, posters, and instructional and resource books.

Contact: New York State Department of Health
Special Supplemental Nutrition Program for
Women, Infants and Children
Riverview Center
150 Broadway, Sixth Floor West
Albany, New York 12204

Telephone: (518) 402-7093

Web: www.health.state.ny.us/nysdoh/nutrition/wic/pages/about.htm

Call the Growing Up Healthy Hot Line at 1-800-522-5006 to locate the nearest WIC local agency clinic

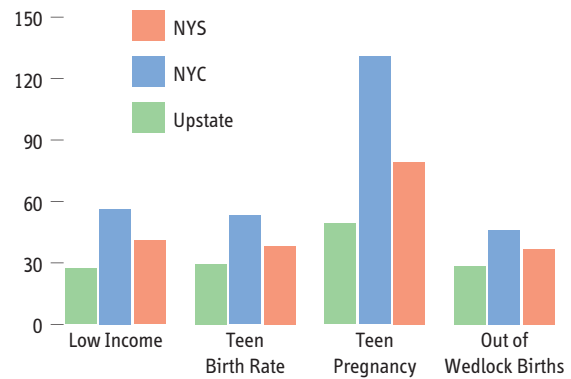
Community Health Worker Program

Background: The New York State Department of Health's comprehensive strategy for improving maternal and newborn outcomes includes direct, one-on-one outreach to high-risk women. Improving maternal and newborn outcomes is dependent on getting women into prenatal care and ensuring that they and their children receive continuing medical care. The emphasis is on early and consistent participation in preventive and primary health care services by low-income, multi-problem families, particularly those with pregnant women. The Community Health Worker Program provides that link between at-risk women and children and the health care system.

Program Description: One-on-one outreach, education and home visiting services are provided to pregnant women who are at highest risk for poor birth outcomes, particularly low-birth weight and infant mortality. The CHWP, like the Comprehensive Prenatal-Perinatal Services Networks program (see this program write-up for additional data), is targeted towards specific communities with high rates of infant mortality, out-of-wedlock births, late or no prenatal care, teen pregnancies and births, and births to low-income (Medicaid or self-pay) women. The program's focus is on engaging pregnant women into early and consistent prenatal care and ensuring their families receive primary and preventive health care services.

Community Health Workers (CHWs) create a bridge between providers of health, social and community services and the under-served and hard-to-reach populations within their community. CHWs are paraprofessionals who are recruited from the targeted communities and are well versed in the culture, activity, lifestyle and language characteristics of those neighborhoods. They use a variety of techniques to conduct outreach and to engage pregnant women and families who are likely to avoid health services for such reasons as substance abuse, domestic violence,

Rate of Births to Low-Income Women, Teen Birth Rate, Pregnancy Rate and Rate of Out-of-Wedlock Births, 1998-2000, Vital Records Data



immigrant status, adolescence and other factors. The CHWs develop a highly individualized approach to each family.

The CHWs develop and maintain a relationship with the family during home visits, which are made at least monthly throughout the woman's pregnancy and throughout the infant's first year of life. Such consistency enables the CHW to assist families to take the necessary steps to improve their health status and family functioning. The ultimate goal is to assist families to develop the necessary skills and resources to move towards self-sufficiency. There are 23 programs currently funded across the state.

Contact: New York State Department of Health
Community Health Worker Program
Empire State Plaza
Corning Tower, Room 1882
Albany, New York 12237-0612

Telephone: (518) 474-1911

Web: www.health.state.ny.us/nysdoh/perinatal/en/index.htm

Comprehensive Prenatal-Perinatal Services Networks Program

Background: New York State has developed a comprehensive strategy to improve women and children's health and to move towards attaining the Healthy People (HP) 2010 goals for all women and children in the state, including those from different races and ethnic backgrounds. (See PCAP/MOMS.) This strategy addresses factors that contribute to poor birth outcomes at a variety of levels: region-wide, through mass media outreach and education; community-wide, through coordination of the local services system, as well as outreach and education; and, at the individual-level, through one-on-one outreach, education and advocacy. The Networks have been developed to improve the perinatal service system on the local level.

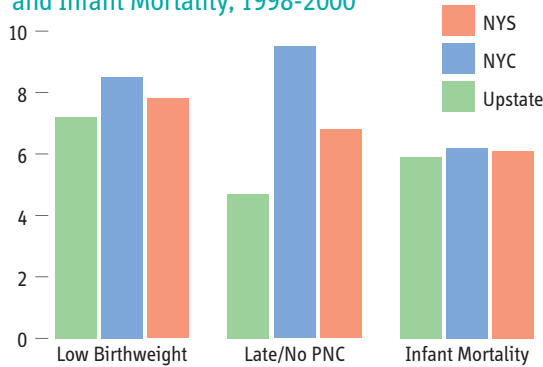
Program Description: The Perinatal Networks are community-based organizations sponsored by the New York State Department of Health whose mission is to organize the service system at the local level to improve perinatal health. Gaps in local services are identified and addressed. Opportunities for collaboration and cooperation are identified to maximize services and to prevent duplication of effort. The networks also sponsor programs targeted to specific at-risk members of the community. The scope of services provided by these networks includes coalition building, and conducting outreach and education to high-risk populations.

The Networks also respond to provider needs for education on special topics, such as screening for substance abuse among pregnant women, or cultural sensitivity training. Each of the 15 Perinatal Networks targets a region, ranging in size from several Health Districts in New York City to large multi-county regions in rural upstate areas. Over the past decade, the Perinatal Networks have become principal contractors for a range of initiatives, including child abuse prevention, lead screening and abatement, Healthy Start, and many others. Networks play a significant role in providing information about and facilitating enrollment in the Child Health Plus program and Medicaid managed care.

Networks develop community partnerships to address the following priorities on the local level:

- Facilitate access to comprehensive prenatal care for pregnant women, particularly under-served,

Rates of Low Birthweight, Late/No Prenatal Care and Infant Mortality, 1998-2000



hard-to-reach pregnant women not engaged in other health or community services;

- Ensure the availability of a comprehensive system of perinatal care that addresses the continuum of perinatal health services: pre-conceptional, prenatal, intrapartum, postpartum, and newborn care; family planning; inter-conceptional services; infant care; and, related maternal and child health services;
- Identify and address community-specific problems that may lead to poor birth outcomes;
- Maximize utilization of perinatal health care resources within the target community through outreach, education, and coordinated delivery of services.

The Networks' community partners include a variety of community organizations such as Prenatal Care Assistance Programs, Community Health Worker Programs, Medicaid Obstetrical and Maternal Services programs, WIC, Healthy Start, Community Action for Prenatal Care Initiative coalitions, adolescent pregnancy prevention programs, Healthy Families New York Home Visiting Programs, family planning and other federal, state, and local maternal and child health and related programs in the community.

Contact: New York State Department of Health
Comprehensive Prenatal-Perinatal
Services Networks Program
Empire State Plaza
Corning Tower, Room 1805
Albany, New York 12237-0612

Telephone: (518) 474-1911

Web: www.health.state.ny.us/nysdoh/perinatal/en/index.htm

Prenatal Care Assistance Program (PCAP)/ Medicaid Obstetrical Maternal Services Program (MOMS)

Background: The New York State Department of Health is committed to improving pregnancy outcomes for all citizens of the state. The health of women and infants is of critical importance in the determination of the health of a community. Measures such as infant mortality, low birth weight, entry into prenatal care, etc., are significant indicators of the well being of a population. The Department has implemented a variety of programs to improve maternal and newborn outcomes. The success of these programs is measured against Healthy People (HP) 2010 goals.

New York State continues to fall short of the HP 2010 goal of 4.5 infant deaths per 1,000 live births. New York State data for 1998 – 2000 indicates 5.9 infant deaths per 1,000 live births. Several factors influence birth outcomes, including late or no prenatal care, the use of alcohol, tobacco, and other substances during pregnancy and the health status of the woman before and during pregnancy. In addition, the disparity in infant mortality and other outcomes between whites and specific racial and ethnic groups remains significant. In order to address these issues in a state as large and diverse as New York, multiple strategies must be implemented to move towards attaining better outcomes for women and newborns.

Program Description: To meet the health needs of pregnant low-income and high-risk women, the Department developed a comprehensive Prenatal Care Assistance Program to improve birth outcomes. The program ensures women access to a full range of health and related services such as obstetrical care, education, nutrition counseling and psychosocial support.

The program was developed in 1985 as a grant program for low-income women not eligible for

Medicaid. Today reimbursement through Medicaid is available for all women with incomes less than 200% of poverty. There are approximately 142 PCAP providers statewide in over 400 sites. Before the widespread development of managed care programs for Medicaid clients, this program served over 70% of the state's 110,000 Medicaid deliveries per year, through a network of 185 hospital-based clinics, freestanding diagnostic and treatment centers, and county health department-based clinics. Approximately 100,000 women received some portion of their prenatal care through PCAP in 2001. The comprehensive prenatal care standards developed for this program have become the standard of care for New York State, and have been mandated for adoption by managed care plans serving Medicaid clients.

Medicaid Obstetrical and Maternal Services (MOMS) Program: Based on the PCAP model of services, this program was developed to provide comprehensive prenatal care services to low-income women in rural or other settings where PCAP sites do not exist. Prenatal care is provided in doctors' offices, while ancillary services such as health education, psychosocial and nutritional screening is provided by a qualified Health Supportive Services Provider. Over 2,000 physicians are enrolled in the MOMS program. The program serves approximately 7,000 women per year.

Contact: New York State Department of Health
PCAP/MOMS Programs
Empire State Plaza
Corning Tower, Room 1805
Albany, New York 12237-0618

Telephone: (518) 474-1911

Web: www.health.state.ny.us/nysdoh/perinatal/en/index.htm

Statewide Summary		Percent Of Births				Infant Deaths 1998-2000	Infant Death Rate	Teen Birth Rate	Teen Pregnancy Rate
Area	Total Births 1998-2000	Low Birth Weight	Out of Wedlock	Medicaid or Self-pay	Late or No Prenatal Care				
Rest of State	409,826	7.2	28.5	27.3	4.7	2,426	5.9	29.3	49.3
New York City	360,022	8.5	46.1	56.2	9.5	2,249	6.2	53.2	130.8
New York State	769,848	7.8	36.8	41.0	6.8	4,675	6.1	38.1	79.2

Regionalized Perinatal Care – Perinatal Re-designation

Background: Regionalized perinatal care is organized around a series of regional perinatal centers (RPCs) throughout the state, each supporting and providing quality assurance and improvement services to a group or network of affiliated hospitals offering varying levels of perinatal care. Research strongly supports a shift from the concept of neonatal designation to perinatal regionalization to ensure the highest quality care for mothers and infants. Perinatal regionalization takes into account factors, which enhance quality of care for mothers, as well as newborns.

Studies have indicated that when a higher level of Neonatal Intensive Care Unit (NICU) care is provided at the hospital of birth and that hospital has sufficient numbers of high risk infants to develop and maintain the skills necessary to care for these infants, there is a significant improvement of neonatal mortality. Women transported to a hospital that can provide appropriate levels of perinatal care prior to delivery also experience a lower rate of morbidity and mortality. A study of maternal mortality in New York found that a frequent contributing factor for poor birth outcomes was lack of high-level care for women with serious underlying illnesses and/or pregnancy complications. Recent studies suggest that transfer of infants prior to birth to appropriate levels of care results in significant reductions of infant morbidity and mortality and a decrease in costs for neonatal care.

The designation levels were previously based solely on the capability of hospitals to provide care to newborns based on information collected in 1985. Since 1985, significant changes in perinatal health have directly impacted hospital designations. Changes include an increase in the availability of neonatologists statewide, advances in technology which increase hospitals' capabilities for caring for at-risk neonates, and changes in hospital affiliations and corporate relationships.

The coordination of perinatal care in each region of the state must be optimized to ensure that pregnant women, new mothers, and their newborns receive care at settings appropriate to their needs. The Department of Health is in the process of updating and refining responsibilities of the perinatal regionalization system for hospitals providing perinatal services statewide. Increasing emphasis is being placed on the quality improvement role of the Regional Perinatal Centers as leaders in the field to promote improved perinatal care across the state. This effort will result in greater access to more appropriate levels of care for pregnant women

and newborns, and strengthen the relationships of the RPCs and affiliative hospitals for purposes of quality improvement.

Program Description: The Bureau of Women's Health and the Office of Health Systems Management have collaboratively implemented a process to provide perinatal designations, reflecting both maternal and neonatal capabilities. The four designation levels are: Basic Care (Level 1), Specialty Care (Level 2), Subspecialty Care (Level 3), and Regional Perinatal Center (RPC). Also for the first time, a hospital's designated level will be placed on the hospital's Operating Certificate.

The Department relied upon extensive input from an expert work group comprised of obstetricians, neonatologists, hospital executive officers, advocacy group leaders, hospital associations, and other stakeholders in developing the process. Revisions to the regulations that govern perinatal regionalization are also being made to incorporate current standards of practice.

A two-step review process was used for the re-designation process. The first step entailed Department review of all survey materials to assess each hospital's perinatal capabilities. Site visits were then conducted by the Island Peer Review Organization and BWH staff to all RPCs, hospitals requesting an increase in designation level or any hospital where there appeared to be outstanding questions as a result of the survey review.

All hospitals, including the Regional Perinatal Centers (RPCs) have received their perinatal designation. In addition to consultation, transport, outreach and education responsibilities, the RPC will provide quality improvement activities among its affiliate network. In collaboration with Comprehensive Prenatal-Perinatal Services Networks, the RPCs have developed regional perinatal forums involving hospital and community stakeholders to identify and address perinatal health issues in each region. (See profile on the Statewide Perinatal Data System for further information about the use of data in quality improvement activities.)

Contact: New York State Department of Health
Regionalized Perinatal Care - Perinatal
Re-designation
Empire State Plaza
Corning Tower, Room 1805
Albany, New York 12237

Telephone : (518) 474-1911

Adult Cystic Fibrosis Assistance Program

Background: Cystic Fibrosis is an inherited disease affecting the endocrine glands which produce mucous, saliva and sweat; the most serious abnormality is that mucous in various parts of the body is too thick, resulting in obstruction of spaces in the respiratory and digestive systems. Left untreated, the disease progressively compromises the lungs; affected people suffer from shortness of breath, fatigue and chest deformity. Infection is a frequent complication. In the digestive system, pancreatic ducts become obstructed and the pancreas atrophies. Insufficient digestive enzyme secretion results in decreased absorption of food, particularly fat. The combination of compromised lung functioning and diminished nutrient absorption is life threatening.

Recent advances in the diagnosis and treatment of cystic fibrosis have significantly reduced mortality from this disease. The average life expectancy for a person with cystic fibrosis is now 32, and many reach middle age. Due to the high cost of medical care, combined with expensive insurance premiums, most patients over the age of 21 must use public assistance and Medicaid. Employment can result in the loss of eligibility for Medicaid, while providing insufficient income to support the high cost of insurance premiums and non-covered medical treatment. Private medical insurance, or that provided through an employer, almost always requires a waiting period for pre-existing medical conditions.

Program Description: In August 1987, Article 27-G was added to the New York State Public Health Law. This article created the Adult Cystic Fibrosis Assistance Program to fill the medical care reimbursement gap that has prevented many cystic fibrosis patients

from achieving their maximum employment potential. Medical care for cystic fibrosis means such diagnostic, therapeutic and rehabilitative care by medical and paramedical care personnel including hospital and related care, drugs, prosthesis, appliances, needed equipment, and devices, as necessary, for the treatment of cystic fibrosis and any conditions demonstrated to result from the progress or treatment of cystic fibrosis. This legislation specifically addresses the insurance and health care reimbursement needs of cystic fibrosis patients' age 21 years old or older.

Enrolled clients are required to meet an annual client contribution (7% of their own and their spouse's net income as defined by program regulations) before they receive reimbursement for paid medical and pharmaceutical claims they have incurred. To assist clients in maintaining their health insurance coverage the program also reimburses clients for their health insurance premiums. The program has aided clients in affording medical and pharmaceutical care by removing the cost barrier to accessing care.

The target population is individuals over the age of 21 who have been diagnosed with cystic fibrosis. Currently the program has 95 enrolled clients, 41 of whom are women. Many of these clients are married with young children and this program has assisted them in maintaining their health to continue working and providing for their families.

Contact: New York State Department of Health
Adult Cystic Fibrosis Assistance Program
Riverview Center
150 Broadway, Third Floor West
Albany, NY 12204

Telephone: (518) 474 -1222



Elderly Pharmaceutical Insurance Coverage (EPIC) Program

Background: New York State leads the nation in helping its seniors pay for prescription drugs. The EPIC program covers approximately 75 percent of the cost of prescription drugs, insulin and insulin syringes. It is available to NYS residents over 65 years of age who are income eligible (up to \$35,000 single and \$50,000 married). Enrollees cannot currently be receiving Medicaid benefits or have other prescription insurance coverage that is better than EPIC.

Currently, more than 322,000 seniors are enrolled in the program. The average EPIC participant is a widowed, female who is 78 years old. All EPIC outreach initiatives are targeted to both male and female income-eligible seniors statewide. This includes seniors living in urban and rural areas, seniors from minority populations, the visually or hearing impaired elderly, and the homebound elderly.

The EPIC program is funded solely with State funds and is not federally subsidized.

Who is at risk: Seniors over the age of 65 who have prescription drug costs but cannot afford the cost of their prescriptions, and seniors with very high prescription drug costs who have no prescription insurance or limited prescription insurance. The EPIC program offers affordable prescription insurance to senior citizens living in NY who meet the eligibility criteria.

Contact: New York State Department of Health
Elderly Pharmaceutical Insurance Coverage
260 Washington Avenue Extension
Albany, NY 12203

Telephone: (518) 452 - 6828

Web site: www.health.state.ny.us/nysdoh/epic/faq.htm



Medicaid/Child Health Plus A/Family Health Plus

Medicaid is a joint federal, state and locally financed program that provides medical assistance to individuals and families whose income and resources are insufficient to meet the costs of necessary medical care. Individuals and families may be covered by Medicaid if they have high medical bills, receive Supplemental Security Income (SSI) or meet certain income, resource, and age or disability requirements. Medicaid for children under the age of 19 is called Child Health Plus A. Medicaid, often in conjunction with Medicare, is an important source of health care coverage for low-income women in New York State, who account for approximately 70% of the adults eligible for Medicaid.

Medicaid covers a broad range of services critical to women's health including inpatient hospital and physician services, prenatal care, family planning and reproductive health care and supplies, mammography and pap smears, therapies, durable medical equipment and supplies, pharmaceuticals, dental and vision care. Medicaid is a major source of funding for long-term care services and prescription drugs for Medicare-eligible seniors and individuals with qualifying disabilities.

Medicaid offers a family planning benefit to individuals not financially eligible for the full Medicaid program (see the Comprehensive FP and Reproductive Health Care Services Program. Application for this program can be made through family planning service providers that have contracted with their local department of social services or at the local department of social services. Full Medicaid coverage is available for individuals not normally financially eligible for full Medicaid, who have been found to be in need of treatment for breast or cervical cancer (see the Healthy Women Partnership Program).

Medicaid also offers a buy-in program for working people with disabilities whose Medicaid covered services enable them to function in the workplace.

Family Health Plus is a Medicaid-financed health care coverage option for adults who are at least age 19 but no greater than age 64, who do not have insurance, and who do not meet the income eligibility requirements for Medicaid. Family Health Plus provides a comprehensive package of health care services including prevention, primary care, hospitalization, prescriptions and other services. Health care is provided through participating managed care plans.

The New York State Medicaid program provides services through two health care delivery systems, fee-for-service (FFS) Medicaid and Medicaid managed care plans. The FFS program provides payment for medically necessary health care and services provided by a wide range of health care providers who enroll as Medicaid providers. Medicaid recipients may choose to see any Medicaid enrolled provider as necessary. Medicaid managed care plans provide comprehensive health care and services to plan enrollees through participating network providers. Recipients enroll in a plan and choose a primary care provider for regular care and for assistance with in-plan referrals for specialty care and services. In many instances, access to health care and services has been improved for Medicaid beneficiaries able to enroll in Medicaid managed care plans.

For Medicaid managed care programs, Medicaid fee-for-service continues to pay for some services such as pharmacy that are not part of the managed care benefit package. Enrollees are also allowed to access family planning services from any Medicaid provider, either in the plan network or through Medicaid FFS. For enrollees in Family Health Plus, the managed care benefit package is all-inclusive.

Individuals interested in applying for Child Health Plus A, Medicaid or Family Health Plus may go to their local social services office or to an enrollment facilitator for assistance. Enrollment facilitators are available throughout the State. Many have evening and weekend hours. To locate an enrollment facilitator in your county, you may call 1-800-698-4KIDS.

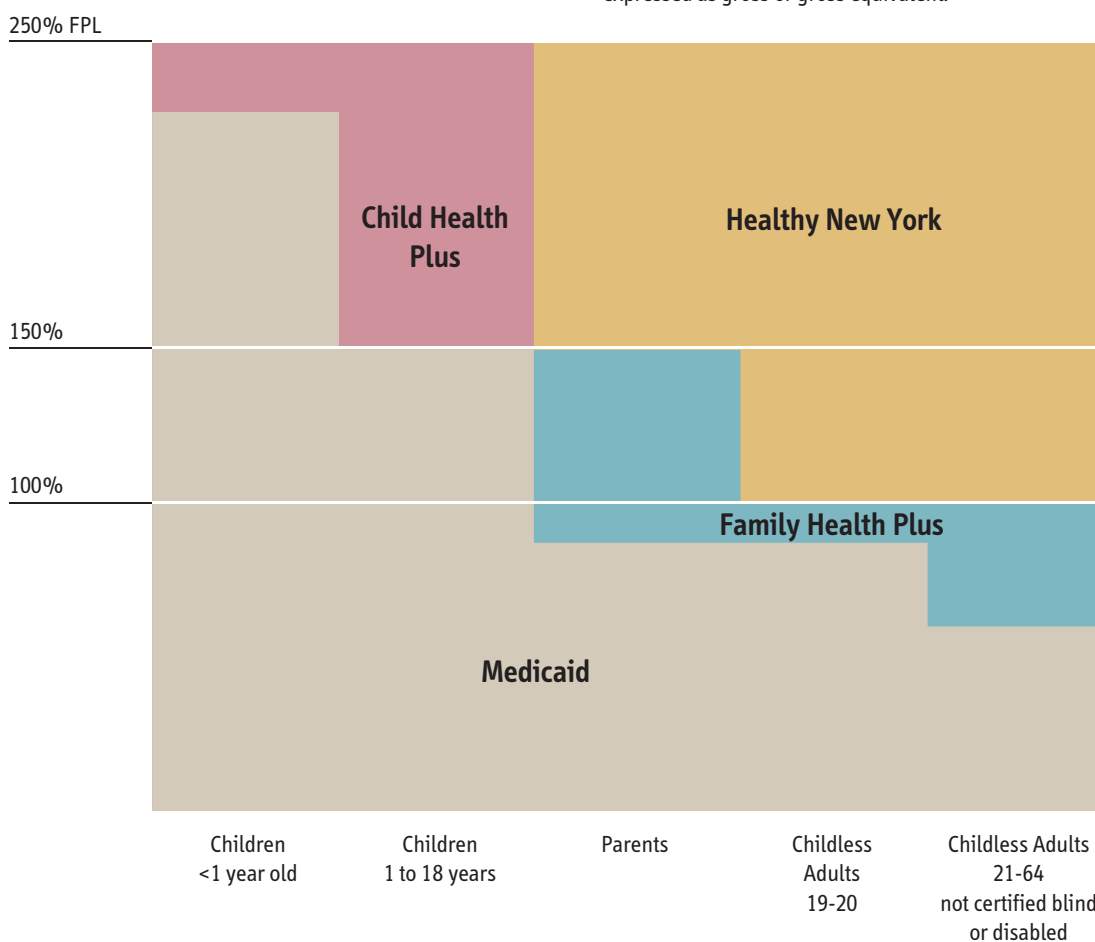
Public Health Insurance Programs For New York State Residents

New York State is committed to ensure all the people of New York State have access to quality health care services. To achieve this, New York funds a number of public health insurance programs for individuals who are uninsured or underinsured. The following table provides information on each of these programs, including the eligibility requirements and application process. More information may also be obtained by accessing the Department's web site.

Web sites: www.health.state.ny.us/nysdoh/medicaid/medicaid.htm
www.health.state.ny.us/nysdoh/fhplus/what_is_fhp.htm
www.health.state.ny.us/nysdoh/chplus/index.htm

Income Levels for Health Insurance Programs

Income eligibility levels are applied as either net or gross. For purposes of comparison, all income levels are expressed as gross or gross equivalent.



Medicaid Including Child Health Plus A

	Eligibility Requirements	How and Where to Apply	Service Delivery System
<ul style="list-style-type: none"> Single adults, low income families, infants, and children. 	<ul style="list-style-type: none"> Family income, if applicable, resource requirements. <ul style="list-style-type: none"> Adults age 19+: NYS income and resource levels. Infants up to age one: at or below 200% FPL. No resource requirements. Eligibility guaranteed up to age one. Children age one up to age six: at or below 133% FPL. No resource test. Children age six up to age 19: at or below 100% FPL. No resource test. U.S. Citizen, National, Native American or an individual with satisfactory immigration status. Undocumented and temporary non-immigrants are eligible only for the treatment of an emergency medical condition. 	<ul style="list-style-type: none"> Assistance by LDSS (in NYC HRA), facilitated enrollers. (some hospitals/community based organizations and health plans) Eligibility application submitted to LDSS (in NYC HRA). No presumptive eligibility. Young adults if living on their own may apply as independent households. 	<ul style="list-style-type: none"> Medicaid fee-for service Medicaid managed care plans
<ul style="list-style-type: none"> Pregnant Women 	<ul style="list-style-type: none"> Family income at or below 200% FPL. No resource requirements. Eligibility guaranteed up to 60 days postpartum. No citizenship requirements 	<ul style="list-style-type: none"> Presumptive Medicaid eligibility Medicaid application completed at all qualified Presumptive Eligibility providers. Full Medicaid applications submitted to LDSS (in NYC HRA). Young pregnant adults may apply as independent households. 	<ul style="list-style-type: none"> Medicaid fee-for-service Medicaid managed care plans
<ul style="list-style-type: none"> Family Planning Extension Program (FPEP) 	<ul style="list-style-type: none"> Women are eligible for FPEP if they were pregnant while on Medicaid but subsequently lost their Medicaid coverage. They are eligible for FPEP for a period of 26 months from the date the pregnancy ended, regardless of the outcome of the pregnancy. No citizenship requirements. 	<ul style="list-style-type: none"> Title 10 family planning providers determine eligibility. 	
<ul style="list-style-type: none"> Family Planning Benefit Program (Waiver) 	<ul style="list-style-type: none"> Men/women with family income up to and including 200% FPL. No resource test. U.S. Citizen, National, Native American or an individual with satisfactory immigration status. 	<ul style="list-style-type: none"> LDSS accept application and determine eligibility. LDSS may sign MOU with family planning providers to take applications. Adolescents may apply using only their own income, even if living with parents. 	<ul style="list-style-type: none"> Medicaid fee-for-service

The New York State Breast and Cervical Cancer Treatment Program (BCCTP)

Eligibility Requirements	How and Where to Apply	Service Delivery System
<ul style="list-style-type: none"> • Reside in New York State. • U.S. Citizen, National, Native American or an individual with satisfactory immigration status. • Meet the Centers for Disease Control and Prevention (CDC) criteria, that is: <ul style="list-style-type: none"> • Be screened by the Health Women Partnership; and • Found to be in need of treatment for breast or cervical cancer; and • Have income at or below 250% of the FPL; and • Not be covered under any creditable insurance; and • Not be eligible for Medicaid under one of the mandatory Eligibility groups. • The Federal program is limited to female individuals under 65 years of age; however, NYS will also cover males and any individuals who are aged 65 and over under a State funded program. • No resource test. 	<ul style="list-style-type: none"> • Individuals go to the local Health Women Partnership. • Designated Qualified Entities (DQE's) at the Partnership provide assistance in completing the BCCTP application booklet and doing the face-to-face interview. • Applications are sent to Cancer Services Program, reviewed for completeness and certified that the CDC screening criteria has been met. • Eligibility and enrollment applications are then submitted to SDOH/OMM for determination of eligibility. 	<ul style="list-style-type: none"> • Medicaid fee-for-service. • Not eligible to participate in managed care. • Must use a New York State enrolled Medicaid provider.

Family Health Plus (FHPlus)

Eligibility Requirements	How and Where to Apply	Service Delivery System
<ul style="list-style-type: none"> • Uninsured Adults age 19 up to age 65. • Not eligible for Medicaid. • Gross Family Income; No resource test. <ul style="list-style-type: none"> • Young adults (age 19 up to age 21) residing with parents and parents with children under age 21 in their households: 150% FPL. • Young adults (age 19 up to age 21) living alone and adults without children: 100% FPL. • U.S. Citizen, National, Native American or an individual with satisfactory immigration status. 	<ul style="list-style-type: none"> • Facilitated enrollers and LDSS provide eligibility application assistance and assist with health plan selection. • Eligibility and enrollment application submitted to LDSS and NYC (HRA). • LDSS/HRA determines eligibility. • No presumptive eligibility. No retroactive eligibility. 	<ul style="list-style-type: none"> • Family Health Plus managed care plans.

Child Health Plus B (CHPlus B)

Eligibility Requirements	How and Where to Apply	Service Delivery System
<ul style="list-style-type: none"> • Uninsured children one month up to age 19. • Not eligible for Medicaid. • Premium subsidized for incomes at 160% to below 250% FPL. Full premium available for incomes above 250% FPL. No premium below 160%. • No citizenship requirements. 	<ul style="list-style-type: none"> • Eligibility and managed care enrollment assistance by facilitated enrollers and MCOs. • Eligibility and enrollment application submitted to facilitated enrollers or CHPlus MCO's. • 60 days presumptive eligibility available when application submitted without documentation 	<ul style="list-style-type: none"> • Managed care plans Commercial and PHSPs.

Healthy NY

Eligibility Requirements	How and Where to Apply	Service Delivery System
<ul style="list-style-type: none"> • Uninsured individuals whose employers do not provide coverage. • Not eligible for Medicare. • Must be NYS resident. • Applicant or their spouse must have been employed in past year. • Income below 250% of the FPL. Only count income of applicant and spouse. • Adult children/students do not count income of parents. • No citizenship requirement. 	<ul style="list-style-type: none"> • Available through every HMO in the state. • Applications: www.HealthyNY.com or 1-866-HealthyNY. • Requires monthly premium. • Can enroll whole family or just the adult(s). 	<ul style="list-style-type: none"> • Family Health Plus managed care plans.

Physically Handicapped Children's Program

Eligibility Requirements	How and Where to Apply	Service Delivery System
<ul style="list-style-type: none"> • Children, 0 up to 21 years, with a severe chronic illness or physically handicapping condition. • Residents of NYS. • Not eligible for Medicaid. • No citizenship requirements. 	<ul style="list-style-type: none"> • Eligibility is determined by the local PHCP. • Apply for the Treatment Program through local health departments (This is a voluntary program, not all local health departments participate in the Treatment Program). • A diagnostic evaluation for a child with a suspected severe, chronic illness or physically handicapping condition may be authorized through the local PHCP even if the locality does not participate in the Treatment Program. 	<ul style="list-style-type: none"> • Diagnostic evaluations are provided through physician specialists and PHCP Specialty Centers. • The state PHCP is billed directly for a diagnostic evaluation. • Treatment services are recommended by physician specialists and PHCP Specialty Centers. • Treatment services are prior authorized by local PHCPs. • The Treatment Program reimburses health care providers for services rendered to eligible children. Providers bill the local health departments.

Elderly Pharmaceutical Insurance Coverage Program (EPIC)

Eligibility Requirements	How and Where to Apply	Service Delivery System
<ul style="list-style-type: none"> • New York State resident. • Over 65 years of age. • Annual incomes of less than \$35,000 for single, less than \$50,000 if married. • Not in receipt of Medicaid. • No or limited prescription drug coverage. 		<ul style="list-style-type: none"> • New York State funded.

Medicaid Buy-In program for Working People with Disabilities (MBI-WPD)

Eligibility Requirements	How and Where to Apply	Service Delivery System
<ul style="list-style-type: none"> • Reside in New York State. • U.S. Citizen, National, Native American or an individual with satisfactory immigration status. • Age 16 through 64. • Engaged in work activity for which financial compensation is received and all applicable income and payroll taxes are paid • Certification of disability. • Total net income at or below 250% FPL. If net income is at or above 150% FPL but does not exceed 250% FPL, a monthly premium payment will be required.* • Non-exempt resources that do not exceed \$10,000. <p>*Monthly Premium for net income at or above 150% FPL but less than 250% FPL equals the sum of 3% of the net earned income plus 7.5% of the net unearned income. Currently, a moratorium exists on premium payments.</p>	<ul style="list-style-type: none"> • LDSS accept the following forms for eligibility determination: <ol style="list-style-type: none"> 1. Application for Public Assistance/Medical Assistance/ Food Stamps/Services (LDSS-2921) 2. Access New York Health Care Form (DOH-4220-1) 3. Medicaid Renewal (Recertification) form 	<ul style="list-style-type: none"> • Medicaid fee-for-service. • Medicaid managed care is available only for those with net income below 150% FPL.

American Indian Health Program

Eligibility Requirements	How and Where to Apply	Service Delivery System
<p>Each Nation establishes eligibility.</p> <ul style="list-style-type: none"> • The services provided for pregnant women and children generally reflect the array of services within the Medicaid Program. 	<ul style="list-style-type: none"> • Each health clinic can inform the client of whom within that nation is designated to accept their application. This may vary due to elections and change in management structure. • A list of the Health Clinics for each nation is below. 	<ul style="list-style-type: none"> • Health care may be provided by a federally recognized Health Department, a state funded Health Clinic run by an Article 28 facility, or, in the case of the Unkechaug Nation, through a referral from the health care coordinator to a participating provider.

American Indian Health Clinics

Tuscarora Nation

Elizabeth Printup, Clinic Manager
Tuscarora Nation Health Center
2015 Mount Hope Road
Lewiston, New York 14092

Unkechaug Nation

Maria Chamorro
Unkechaug Nation Health Services
Poospatuck Lane
Mastic, New York 11950

Shinnecock Nation

Jennifer Concepcion Arline, Clinic Manager
Shinnecock Nation Health Center, Church Street
Southampton, New York 11969

Tonawanda Seneca Nation

Dara Beth Fortes, Clinic Manager
Tonawanda Seneca Family Care Center
372 Bloomingdale Road
Akron, New York 14001

Oneida Nation

Charmine Frederick, Clinic Manager
Oneida Indian Health Department
2 Territory Road
Oneida, New York 13421

Onondaga Nation

Joan Diehl, Clinic Manager
Onondaga Nation Health Center
Route 11A Onondaga Nation Territory
Nedrow, New York 13120

St. Regis Mohawk Nation

Rob Cree, Assistant Health Director
412 State Road, Rt. 37
Akwasasne, New York 13655

Dental Health

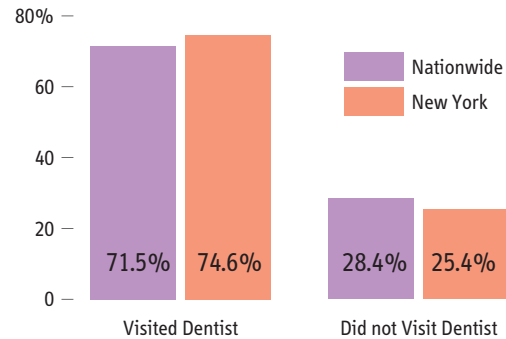
Background: The Bureau of Dental Health implements and monitors statewide dental health programs that prevent, control and reduce dental diseases and other oral health conditions, and promote healthy behaviors. In addition to maintaining the focus on children, programs promote dental health among adult populations including pregnant women. The Dental Health programs:

- Assess and monitor oral health status.
- Provide guidance for planning and policy development to support community efforts directed toward assuring the oral health.
- Mobilize community partnerships to design and implement programs directed toward prevention and control of oral diseases and conditions.
- Inform and educate the public regarding issues related to healthy life style, health plans and availability of care.
- Integrate oral health programs and policies into other health care programs.
- Assure the capacity and promote the competency of public health dentists, general practitioners and dental hygienists.
- Evaluate the effectiveness, accessibility, and quality of population-based and personal services.
- Promote research and demonstration programs to develop innovative solutions to problems.

Oral Health: Oral health is integral to general health. A woman's oral health needs may change at various stages of her life and good oral care is important. Not only can poor oral health and untreated oral diseases significantly impact quality of life, recent studies have suggested an association between chronic oral infections and serious health problems, such as diabetes, heart and lung disease and adverse pregnancy outcomes. It is important that women have a complete periodic (as per their dentist recommendation) oral examination and do all they can do to maintain optimum oral health. Behavioral Risk Factor Surveillance System (BRFSS) data indicate that in the year 2002, 75% of women visited their dentist in New York State. A coordinated effort from the dental and health care communities could improve the oral health and overall health of all women.

Special Initiatives: The New York State Health Department is supporting New York University's program for pregnant women, which was designed to empower, educate and Healthy Mouths/Healthy Babies Project. This oral health promotion addresses the needs of young Hispanic and Native American pregnant women in the New York City area. The mother-to-be

Dental Visits by Women within the Past Year for any Reason, 2002



receives an oral screening and is then involved in an educational workshop that stresses the importance of periodic check ups, early application of preventive strategies, proper nutritional information, oral hygiene practices and early referral of children to the dentist. For information on this program, contact:

Director of Public Health and
Health Promotion
New York University College of Dentistry
345 East 24th Street
New York, NY 10010
(212) 998-9970

The Clinton County Health Department has developed a successful program in promoting oral health messages within their MOMS (Medicaid Obstetrical Maternal Services) Program. Oral health information, dental supplies and one-on-one education is given to pregnant mothers during their prenatal and postnatal visits. To learn more about this program, please contact:

Clinton County Health Department
133 Margaret Street
Plattsburgh, NY 12901
(518) 565-4862

The Bureau of Dental Health has available a PowerPoint presentation on the effects of pregnancy on the oral health of women. The presentation focuses on the importance of oral hygiene practices, eating habits and professional dental care needs.

A train-the trainer program is available to assist health professionals in improving the oral health needs of pregnant women or their infants. For information on this resource, contact:

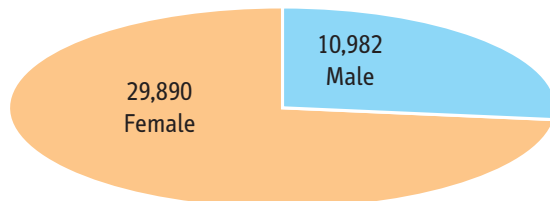
Contact: New York State Department of Health
Bureau of Dental Health
ESP, Corning Tower, Room 542
Albany, NY 12237

Telephone: (518) 474-1961

Injury Prevention Program

Background: The Bureau of Injury Prevention identifies and monitors where and why injuries occur across the state and assists in the development of programs to prevent them. The most recent data available shows that injuries are the leading cause of death for New Yorkers ages 5-24 years and are among the top causes of death for all other age groups. Almost 4,200 New Yorkers die every year as a result of injury. Additionally, injuries are consistently among the leading causes of hospitalizations for New Yorkers of all age groups.

Hospitalizations Due to Falls, NYS Residents, 1998-2000



Mean Annual Frequency - Ages 65+

Falls Prevention

In NYS fall-related injuries are the leading cause of injury hospitalizations among persons 65 years and older. Hip fractures are the most common injury sustained in a fall and most falls occur in the home. The mean annual frequency for women age 65 years and above for a fall related injury was 29,890 for years 1998-2000. Frequently a person is hospitalized for a fall-related injury and the downward spiral begins that results in long term care or death.

Program Description: Fall-related injuries can be reduced and the consequences mitigated with a three-prong approach including education, enforcement and engineering changes. Exercise and strength training, as well as education programs for older adults have proven to reduce the risk of fall-related injury. Enforcement of housing codes in relation to stairs and handrails, and screening by medical professionals also contributes to reducing the problem. Environmental changes such as carpet treads on stairs, non-stick padding under rugs, installation of bathroom rails and tub mats are a few of the engineering approaches that have proven to reduce injury risks in older adults.

The Bureau of Injury Prevention serves as a resource to local health units, county offices for the aging, and other local entities working to reduce the risk of fall-related injuries in their communities. Current research studies and educational information is sent to injury

prevention practitioners to assist them with injury prevention activities with older adults.

Child Passenger Safety

Background: Motor vehicle injuries are the leading cause of death among children at every age group after their first birthday. According to the Centers for Disease Control and Prevention (CDC), a child is killed or injured in a motor vehicle crash every 90 seconds in the USA. Nearly half of the children under 5 who were killed in motor vehicle crashes were riding unrestrained. Child safety seats reduce the risk of death by about 70% for infants and by about 55% for toddlers ages 1 to 4. Only about 6% of children ages 4 to 8 ride in booster seats, the recommended safety seat for this age group.

Program Description: The Bureau of Injury Prevention conducts a Child Passenger Safety Program to reduce the incidence of motor vehicle crash-related injuries to children under age 4. Riding unrestrained is the greatest risk factor for death and injury among child occupants of motor vehicles. Often, women are the primary caregivers to children of this age or are responsible for making decisions about child-related purchases, such as the selection and purchase of a car seat. Therefore, the Bureau of Injury Prevention pays special attention to this group by providing targeted educational materials to medical professionals, specifically pediatricians and obstetrics/gynecological health care providers. In addition, child passenger safety training sessions are conducted for parent education classes and childbirth education classes in communities throughout New York State. Other Bureau efforts focus on the distribution of car seats to low-income families through safety seat check up events and permanent child safety seat fitting stations across New York State.

The Bureau of Injury Prevention also conducts a Booster Seat Promotion Project to increase the use of booster seats by children aged 4-8 while riding in motor vehicles. Research has proven that a child aged 4-8 is typically too small to be adequately protected by a car's restraint system (seatbelts) alone since these devices are designed for adult-sized bodies; booster seats are designed to compensate for a child's smaller stature and help the seatbelt fit a child's body more effectively, which results in better protection during a crash. Parents are the target audience for some of the Bureau's booster seat education campaigns since parents do not always perceive their children to be at a great enough

risk to warrant the purchase and use of a booster seat. Additionally, the Bureau provides booster seat education materials to local communities for distribute to target parents through WIC clinics, day care centers, schools and community agencies, many of which traditionally have a large female clientele. In recent years, the Bureau implemented a CDC-funded Booster Seat promotion project in three target communities that included unique, interactive school-based education and booster seat distribution.

Occupant Restraint

Background: According to the National Highway Traffic Safety Administration, safety belt use reduces the risk of dying in a motor vehicle crash by 44% for front-seat occupants. Over half the people involved in fatal crashes were not wearing seat belts. Proper seat belt use also reduces the risk of moderate to serious injuries by 50% for front-seat occupants. Pregnant women need to take special care as motor vehicle crashes account for two-thirds of all serious traumas during pregnancy.

Program Description: The Bureau of Injury Prevention's Occupant Restraint Project seeks to increase usage of seat belts among all occupants in a motor vehicle. Women are the target for the "Love Me/ Buckle Up?" campaign, which urges women to encourage seat belt use by the men in their lives. The campaign places an emphasis on the important role women play in influencing men's decisions and also appeals to their own ability to improve their safety while riding in a motor vehicle. The Bureau of Injury Prevention also addresses female adult occupant restraint through educational training programs that are conducted for both professionals and the public at large.

Fire Related Injuries

Background: Every 27 minutes someone is killed or injured in a residential fire. Data show that adults over the age of 64 and children under the age of five are most at-risk for fire-related injury. In NYS these two age groups account for 44% of all fire related deaths and 25% of all fire related hospitalizations.

Program Description: The Bureau of Injury Prevention conducts a CDC-funded project to increase the number of functioning smoke alarms, increase the number of households that practice fire escape plans and decrease the number of fire-related injuries and deaths in New York State. Through this program, which impacts women in many ways, smoke alarms have been installed in residences and occupants have been educated about fire safety and fire escape plan-

ning. Older adult women, many of whom have out-lived their spouse and now reside alone, have benefited from individual instruction. In order to reach special populations, a program is being initiated that addresses the needs of single parents of small children, many of whom are women, teaching them safe fire-escape methods for infants and toddlers and taking into consideration their special needs for fire safety and fire escape planning.

Pedestrian Injuries

Background: In New York State, pedestrian-related injuries are one of the leading causes of death and hospitalization due to injuries among persons 14 years and younger and 65 years and older. For children age 5 to 9 years pedestrian injuries are the second leading cause of death and hospitalization due to injuries. For children 10-14 years pedestrian injuries are the second leading cause of injury deaths and the fourth leading cause of injury hospitalization. Between 1998-2000 37% of pedestrians killed in NYS in a traffic related incident were 65 years of age and older. Women accounted for 53% of these deaths with an average of 76 deaths per year.

Program Description: The Bureau of Injury Prevention's Pedestrian Injury Prevention Program focuses on children ages 0-14 and adults age 65 and older, as they are at the greatest risk for pedestrian injuries. The Bureau creates and continues to develop new initiatives that promote safe walking by providing age-appropriate prevention education, by participating in community coalitions that focus on traffic safety and cardiovascular health, and by providing injury prevention training to local public health and traffic safety professionals statewide. For example, senior women, who may rely on walking as a primary means of transportation due to the loss of a spouse who drove, are a unique target population. The Bureau's "Walk Aware" campaign includes pedestrian safety tip sheets for children and older adults and pedestrian safety promotional incentives. The "Some of My Best Friends Are Pedestrians" campaign that targets driver behavior increases awareness regarding the safety of pedestrians in or near traffic. The Bureau also serves as a resource for local program efforts such as "Walk Our Children To School" programs that focus on getting parents and children to walk together.

Contact: New York State Department of Health
Injury Prevention Program
Riverview Center
150 Broadway, 3rd Floor West
Albany, NY 12204-0677

Telephone: 518-473-1143

Web: www.health.state.ny.us/nysdoh/injury.main.htm

Migrant and Seasonal Farmworker Health Program

Background: Migrant agricultural workers are a high-risk and hard-to-reach population facing unique barriers in accessing and sustaining contact with the health care system. Migrant workers and their families are distanced from the health care system by geography, culture, language, and a lack of knowledge and material resources. The migrant workers' mobility makes continuity of any health care a challenge. Each year, between 15,000 and 70,000 migrant and seasonal farmworkers come to New York to perform skilled, manual tasks needed to get New York's crops planted, tended, harvested, processed and prepared for market, or to care for agricultural animals.

Diseases such as hypertension, arthritis, alcoholism, diabetes and dental caries are common. Medical conditions often become serious before attention is sought resulting in increased time away from work, potential for disability, and increased cost of treatment. The nature of farm work predisposes migrant workers to occupational injuries and hazardous exposures. Farm work is ranked the third most hazardous occupation in the nation behind mining and construction. Common occupational health concerns for farmworkers are associated with excessive sun exposure and increased risk for musculoskeletal trauma and degenerative disorders. Dermatitis, respiratory problems, and other consequences of exposure to natural fungi, dust and pesticides are common.

Program Description: The Migrant and Seasonal Farmworker Health Program funds 16 contract agencies (nine county health departments, three community health centers and four other community-based or-

ganizations) that provide services to migrant and seasonal farmworkers and their families in 22 counties in New York State. Twelve of the 16 programs provide direct care services in combination with enabling services designed to reduce barriers and increase access to care. Increasingly primary medical and dental services are supported by federal funds through three Migrant and Community Health Centers.

Each contractor provides a different array of services that may include some/or all of the following: outreach, health screening, primary and preventive medical and dental services, case management, translation, transportation, health education and linkage to services provided by other health and social support programs. Services are designed to reduce the barriers faced by migrants in accessing care, such as inconvenient hours, lack of bilingual staff, lack of transportation, lack of follow-up. A mainstay of migrant health services is outreach, screening, referral and follow-up activities provided to migrants in camps. Migrants referred for primary medical and dental care are supported in obtaining care through transportation, interpretation, and case management services. In 2002, approximately 11,500 migrant workers and their family members received medical/nursing services and 2,499 received dental services.

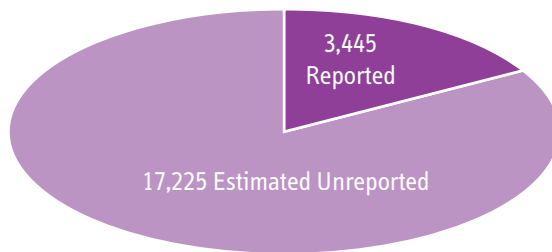
Contact: New York State Department of Health
Migrant and Seasonal Farmworker
Health Program
Empire State Plaza
Corning Tower, Room 890
Albany, NY 12237

Telephone: 518-474-6968

Rape Crisis Program (RCP)

Background: Thousands of rapes and sexual assaults are reported every year in New York State, yet it is estimated that only one in every six rapes is reported. In 2001 there were 3,445 rapes reported to the police for a rate per 100,000 of 18.1%.

Number of Forcible Rapes in NYS, 2001



Program Description: Fifty-five DOH-funded Rape Crisis Centers (RCCs) offer services in 77 sites throughout NYS. The RCCs provide a variety of services designed to prevent rape and sexual assault through preventive education within the community. Over 118,000 individuals, of whom 69% were children and adolescents, received sexual assault prevention education. RCCs also ensure that quality 24-hour crisis intervention and counseling services are available. Approximately 152,700 distinct services including advocacy, support, outreach and education were provided by RCCs during the 2001-02-time period. Medical and criminal justice accompaniment and advocacy, as well as a full range of indicated medical, forensic and support services, are available to survivors of rape and sexual assault. Approximately 25,300 professionals, including those from the medical and criminal justice fields attended training sponsored by the RCCs during 2001-02.

In addition to funding RCCs in every county and borough of the state, the Department of Health has taken a number of actions to improve the health system's response to sexual assault. In conjunction with a panel of experts and advocates, the RCP has updated and

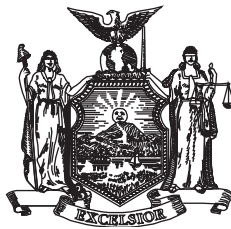
significantly expanded The Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault. The Protocol is designed to ensure consistent high quality treatment for rape survivors, as well as facilitate proper collection of forensic evidence in hospital emergency departments.

The RCP continues to support the Child Abuse Medical Provider (CHAMP) Network initiative undertaken by the Child Abuse Referral and Evaluation (CARE) program located at the SUNY Health Science Center in Syracuse. The goal of CHAMP is to improve access to quality medical care for suspected child abuse victims by providing practitioners with the assessment and diagnostic skills to treat these children. The CARE Program is also revising and expanding the Child and Adolescent Sexual Offense Medical Protocol, published in 1997. When finalized, the Protocol will be put on a Web site for practitioners who provide services to children and adolescents.

The passage of the Sexual Assault Reform Act (SARA), signed into law in 2000, significantly expanded the role of the Rape Crisis Program in addressing sexual assault in NYS. SARA required that DOH designate interested hospitals as sites for Sexual Assault Forensic Examiner (SAFE) Programs. Full implementation of the hospital-based SAFE Program initiative will ensure that access to the highest quality of medical care and forensic evidence collection will be available to survivors statewide. Establishment of SAFE Programs will aid the sexual assault survivor in restoring her maximum wellness, and will provide practitioners with clear and consistent standards of care to follow when treating survivors of sexual assault.

Contact: NYS Department of Health
Rape Crisis Program
Empire State Plaza
Corning Tower, Room 1805
Albany, New York 12237

Telephone: (518) 474-3664



State of New York

George E. Pataki, Governor

Department of Health

Antonia C. Novello, M.D., M.P.H., Dr.P.H.